THE

LARYNGOSCOPE.

VOL. VIII. ST. LOUIS, MO., APRIL, 1900. No. 4.

ORIGINAL COMMUNICATIONS.

(Original communications are received with the understanding that they are contributed exclusively to THE LARYNGOSCOPE.)

THE PAST AND PRESENT OF LARYNGOLOGY.*

BY ORLANDO B. DOUGLAS, M.D.

Mr. Chairman:—I congratulate you—and fellows of the Section—on the degree of prosperity attained by this Association; and not only by the Association, but by the science it stands for. As we have been attracted to this work, believe it worthy of our best efforts, and have espoused it for life, through evil as well as good report, it is gratifying to know that others appreciate it also, and join our forces for the suppression of the greatest evil that, immediately and remotely, has befallen the human race—disease of the upper-air passages and their accessory parts.

It is not necessary, before a body of eminent specialists, to laud their labors or to commend the wisdom of their choice and the success of their work, but we may, with profit, consider what they and their predecessors have done toward perfecting an important department of medicine and surgery.

It has been said that history is the only study worthy of our time and labor. It is certainly an important part of a liberal education, but more than that, to know what *has* been is to know what *shall* be. By studying the past we learn of the work done by and appreciate the labors of our predecessors. We utilize their experiences, accepting the good and rejecting the bad. However depressing it may be to small minds to discover that much of their boasted wisdom is plagiarized, it broadens and strengthens the honest and progressive man to know the foundations that have been laid, upon which he may build. We justly honor our explorers, the discoverers of new worlds, new fields and new truths. He, too, is entitled to honor who

*Read before the Section on Laryngology and Rhinology of the New York Academy of Medicine, January 24, 1900.

makes best use of these discoveries, appreciating that discovery is but the beginning of progress and lays upon him new obligations to cultivate and improve them. It is the part of wisdom to gather up knowledge and carefully sift and winnow out the good and true. In doing so he will find plenty of chaff always, but it will be careless work that does not find good grain in paying quantity. Not the least important part of this process is to note the proportion of worthless material to that which experience and good judgment can use to advantage.

The term Laryngology, as defined by Elsberg twenty years ago, "Embraced all affections of the larynx, trachea, root of the tongue, valleculæ and hyoid bone, tonsils, palate and uvula, pharyngo-nasal space, nasal passages, frontal sinuses, thyroid body, parotid and sublingual glands, the areolar tissue and other structures that make up the anterior portions of the neck." And, as if not sufficiently comprehensive, he adds, "As the mucous membrane of the throat is continuous with that of the whole alimentary tract; of the bronchi and their ramifications; through the pharynx and nasal fossæ with the sphenoidal, ethmoidal and maxillary sinuses; through the lachrymal ducts with the conjunctivæ; and through the Eustachian tubes with the mastoid cells and tympanum, diseases of *these* regions must sometimes be considered by the laryngologist."

"The connection between throat diseases and diseases of other parts of the body is so intimate that no one is competent to be a throat specialist who has not had a previous thorough medical education and considerable general clinical experience;" this is no mean accomplishment for any man.

In the twenty minutes or so allowed for this paper it will be impossible to do more than glance over the work done, not even mentioning the names of all who have studied and written upon the subject before us. We may read in the aphorisms of Hippocrates, the histories of Herodotus and of earlier Greek writers, references to nasal and throat troubles. Ever since there were noses, throats and ears they have been subject to diseases. The great Galen recorded his observations respecting coryza and other troubles that *we* are called upon to relieve; and so all the way down to the present century we may read—sometimes with amusement and amazement—the methods adopted by our professional ancestors to relieve catarrh. And, yet, honorable men of our profession and generation have asserted in this academy, that they knew catarrh could not be cured for they had tried their best and failed.

Hastily glancing backward, our attention is arrested here and there by conspicuous figures and epochal periods, the most important and

successful being well within the memory of men here present. Horace Green, the pioneer in American laryngology, great in all the essentials of greatness, a thorough cultivation, an honest purpose, confidence in his ideals, true to his convictions, brave, persevering, successful, was born the night before Christmas, 1802. "His genius and dexterity penetrated and dispelled much of the darkness which had hung over the subject of laryngeal disease. He lived to see his almost miraculous predictions verified, his researches confirmed and his bitterly criticised precepts and practice vindicated." He died of pulmonary disease in 1866.

A most important event in the history of our specialty was the invention of the laryngoscope. Garcia had succeeded in seeing the vocal bands by means of a mirror, but it was left for Johann Czermak to bring to our use a more perfect apparatus, first used in Vienna in 1858, but brought to New York the same year by Dr. Ernest Krackowizer.

I began my medical studies in 1858, and though not appreciating its subsequent advantage to me, I remember something of the commotion the laryngoscope wrought. Like many another excellent innovation, it was criticised and condemned by some, ignored by many of our profession and approved by a few. Among the latter, and one of the first to take special instruction from Czermak, was our own Elsberg. He instituted the first free throat clinic in America, and gave the first course of lectures here, upon laryngology, in 1861. He died in 1885, but not until his energetic labors had been rewarded by a great awakening to the importance of his loved specialty.

We may justly be proud of the achievements of many of our own fellows of this academy, but our time and purpose to-night will not permit us to review their work in detail or to speak of the magnificent work done by many other specialists in our own country and abroad.

It is interesting to look over early American literature relating to diseases of the nose and throat. In Elsberg's bibliography of published articles, from 1809 to 1878, I find that during the first twenty years, *i. e.*, to 1830, there were sixty-five publications, of which number thirty-one related to croup in its various phases; seven to the tonsils; seven to the larynx; six to foreign bodies; three to the palate; two to the uvula; two to "mouth disease," and one each to whooping cough, tumors, "nose polypus" and aphonia. During the next twenty-nine years, to 1858, when the laryngoscope came into use, there were five hundred and thirteen papers published, while in the twenty years following, to 1878, fifteen hundred and eighty-three articles, relating to laryngology in its broadest sense, were given to the world. We find no reference to nasal troubles till 1820, when Trowbridge

published in the *Medical Repository* his paper on nose polypus. In 1829 Arman published something on the same subject. Horner gave in the *American Journal of Medical Sciences*, in 1830, the first article we find on ozena and another article upon the same subject in 1835. During twenty-two years, of the seventy-five papers published, only three related to the nose—four per cent. In the next twelve years ninety-three were published, twelve of which were upon nasal diseases —about thirteen per cent. And we find more and more attention paid to the nose as the years passed.

The progress made in the last forty years has been largely due to *special study* and investigation of causes of disease, therapeutics and surgery keeping well abreast of the knowledge gained. It is hardly a debatable question whether it is better that a man should know something about all things or all about some things. Genius devotes itself to the latter, observing and recording details. Quality is more important than quantity. Thorough work has brought our specialty to the front and commanded respect from such as we would respect. Scholarly, experienced, enthusiastic workers have directed us in the past; there has been a self-sharpening system, stimulating emulation and rewarding devotion.

The purpose of this paper is not to criticise men or methods, rather it is a reminiscence, and we may commend honest effort though results be faulty. Imperfect work must be condemned, and we could find employment for all our time in pointing out defects in theories and practice in the immediate and remote past. Experience has taught each of us that because a thing is old it is not necessarily sound. Neither is the unseasoned *new* wholly reliable. We live in an age of investigation—an etiological period of the world. Theories are challenged, antiquated methods criticised, that which bears the sacred seal of age is subjected to tests, and prying eyes and searching investigation penetrate our petrified possessions. Ignorance is no longer a safe subterfuge.

Greater New York has more than one hundred hospitals and dispensaries, of which eighty are supposed to treat more or less cases of nose and throat disease. Of the 509,892 patients treated in forty-one hospitals, 391,550 are reported as "out patients," and of this number, 34,408 were treated in nine hospitals for diseases of the nose, throat and ear by two hundred and eleven surgeons. It would be interesting to know just the number of surgeons employed in all these hospitals, and the number of hours of service given by them to this work. Also, the total number of patients treated, and the results of treatment; the number of persons employed, and the time devoted to the care of patients, rooms and appliances; the value of all such

service, and of the buildings, instruments, apparatus, medicines, etc., used in this work. If we add to this the work done in private practice, and its value, the total would doubtless surprise us. Figures to represent all this might be approximated, I presume, but many hours spent in the search revealed only the figures given. Yet these are sufficient to impress upon us the magnitude and importance of our work.

It is an exalted privilege to be associated with men in so grand a work, to aid in relieving so large a proportion of all human suffering. It should be an inspiration to do better work, and prove ourselves worthy to bear the mantle that has fallen upon us.

There is great need for *perfecting the work in hand*, and while it is much more difficult to analyze the immediate present than all the past, our intimate surrounding is our field for work. To quickly grasp the situation and skilfully manipulate present opportunity can alone bring success, and success is a duty we owe to our predecessors and to posterity, as well as to our patients and ourselves.

What remains to be developed? The best that is in us, and infinite possibilities in the realms of the unknown. The forces of Nature have never been exhausted or even impaired. There are secrets to be revealed that are just as wonderful as any discovered. Nature loves her lovers, she is coy, but frank, and opens her stores freely to her sincere devotees. When Czermak brought out the laryngoscope, was there nothing to be done? Carl Koller gave us cocain, but the marvelous virtues of supra-renal capsule remained unknown. O'Dwyer's intubation methods came to us in the last fifteen years. It is the unexplored that allures, the unknown that attracts. There are *bonanzas* in future possibilities. Enterprise is essential, there is no progress without it. But our zeal for the new must not make us unmindful of the old or overlook the helps we have. Routine work is monotonous and tiresome when we have no other motive than to get through with it. It has been said, I think by Tyndall, that every department of science is dependent upon every other department. This is true in medicine. No one department or specialty can stand alone.

I submit for your consideration and discussion the following questions:

1. What has brought you the greatest success in treating diseases of the nose and throat?

2. What is the greatest need, what do we most lack, in the successful treatment of these diseases?

3. Along what line of investigation, in nose and throat work, promises best results, the object being to relieve the greatest amount of human suffering?

123 E. 36th street, New York, N. Y.

ASSOCIATED FRONTAL SINUS AND MASTOID DISEASE.

BY THOMAS J. HARRIS, M.D., NEW YORK.

The following case is reported on account of its unusually peculiar and confusing history:

J. C., aged seventeen, South American, presented himself at the Manhattan Eye and Ear Hospital in August, 1896, for pain in left mastoid.

There was a history that in a voyage North during the preceding spring he had been seized with violent pain in left mastoid, followed by unconsciousness. A local physician was called in at the island of Hayti, where the vessel stopped, and performed a mastoid operation. The young man at once proceeded to this country. The intense pain had disappeared after the operation, but, according to his statement, he was never entirely free from pain, even being prevented at times from sleeping. At this time no pain was complained of elsewhere than in the mastoid region. Examination showed tenderness over mastoid, the presence of a recent scar, and a suppurating middle ear. The case was admitted to the hospital and the usual course of ice locally and hot douching followed. The pain ceased after a couple of days—there was no temperature and patient was discharged.

He left for Chicago, where pain returned. On his return to New York he again consulted me and was readmitted to hospital, September 14th. The classical Schwartze mastoid operation was performed on September 15th. Much diseased bone was discovered and removed and communication freely established with attic. Convalescence was rapid, and on the second day he sat up; temperature normal. The pain was not entirely relieved, but much reduced. About this time he began to complain of pain in the region of the frontal sinus. My recollection is that during the preceding month he referred to headache there, but I paid no attention to it, as it seemed to radiate from the mastoid. The nose was inflamed, especially in the region of the middle turbinals catheterization of frontal sinus, although not bringing away pus, gave relief to pain on two occasions. There was a large amount of purulent matter in right side of nose continually, strongly suggestive of sinus disease on that side. I was unable to discover any disease of the ethmoid cells, however, and believed I was dealing with an empyema of the frontal sinus.

On the morning after the third catheterization, September 27th (tenth day after operation), I was called to the hospital in haste, with the report that the patient was in a condition of collapse. It seemed that almost directly after his visit to my office he had been seized with violent pain in the forehead, which did not yield to any form of analgesic. My memory is that I had employed a weak solution of peroxide of hydrogen in the syringe. Some strong mental treatment seemed to quiet him for the present, but from now on there was constant severe pain in forehead. It is important to note that on the day preceding the last catheterization spoken of, the hospital notes mention severe pain in the forehead. The patient was given all forms of outward application and internally morphine, sodium bromide, phenacetine, quinine, Warburg's tincture, but without any effect on his severe suffering. You will notice during all this time the temperature remained normal. The mastoid wound remained in a healthy condition and healed rapidly.

On October 17th I determined to open the frontal sinus, which I did by the Luc method, but with the exception of a spot of what seemed bare bone nothing was discovered. A drainage tube was carried into and through the nose and the wound in the integument closed up. This operation brought no relief to the pain. From now on the condition became steadily worse. Nothing seemed to control the pain. The wound in the forehead healed, and as no pus came through the tube this was removed. For the next ten days the temperature remained elevated about one degree; on the 27th it rose to 102°. The patient showed now distinctly a typhoid state; there was obstinate constipation, the pulse rose to some over one hundred and sordes was present on teeth and tongue.

There was present much of the time a noisy delirium. On the 28th the recent wound in the frontal sinus was again opened under chloroform with an idea that possibly pus was retained. The sinus was found entirely free from all secretion. This time I allowed the wound to remain unclosed for purposes of observation. On the day following, the patient was placed on iodide of potash. There was no surprising result and the morphine had to be continued in full doses. On November 3d, the fifth day after beginning the potash, an improvement was first noticed. The general condition, which had been regarded critical, slowly improved.

The pain continued in paroxysms. The bowels still were very costive. Delirium persisted as late as November 8th, ten days after taking the iodide. The chart notes fits of crying and rolling of eyes. The discharge from ear persisted. He was now able to sit up and was discharged November 18th, with the pain virtually gone from forehead.

During all this time the discharge did not entirely stop in ear. For a period of possibly two weeks all pain seemed to be gone and he seemed to be in a convalescent condition. Then pain returned in the mastoid. This persisted, and after careful examination I decided that there was still diseased bone in the mastoid region and took him again into the hospital, where we did a modified Stacke operation, finding much diseased bone. This relieved the pain. Convalescence was uninterrupted. I saw the patient frequently during December and January, and his general condition was good; the ear was practically well. There was, however, a persistent complaint of more or less frontal headache, not violent as formerly, but annoying. The case was seen in consultation by several of the attending surgeons, but nothing new elicited. Finally, about February 1st, I determined to send him home to Brazil. Since arriving there I have learned he was feeling very well. In presenting this report I regret I have nothing definite in the way of an explanation for the curious symptoms present.

It has been to me a baffling case. It will be recalled that a certain amount of frontal pain was present from the start; while, too, it is undoubtedly true that no relief was obtained until iodide of potassium was started, I hesitate to conclude the condition was specific. Granted that that condition exists among most of the South Americans, yet here was a boy of seventeen where no history or other symptoms could be obtained. Dr. Chas. H. Knight, who saw the case, inclined to this opinion, however. Dr. Andrew H. Smith believed we had to deal with a pachymeningitis. I fail to find any case reported where the meningeal trouble seemed to have as its chief symptom violent frontal pain.

The unquestionable hysterical element was not to be lost sight of. It is difficult, however, to estimate how far this was an important factor. I have presented the report here, hoping that in the wide experience of the gentlemen present an answer to the question: How far inflammation by continuity from a chronic mastoid is possible to extend to the region near the frontal sinus?

I am free to confess that while I never could diagnose it, I have always suspected an empyema of the sphenoidal sinus. There was for the most part profuse discharge, muco-purulent in nature, only partially checked by curetting and cleansing. Excessive sensibility always prevented any careful probing beyond the ethmoidal region.

117 E. Fortieth Street.

A CASE OF CARCINOMA OF THE PHARYNX.

BY DR. GOTTLIEB KLÆR, COPENHAGEN, DENMARK.

The patient is a man, forty-five years old, who has previously enjoyed good health. He denies to have had syphilis. For the past month he has had a slight pain in his throat with deglutition, especially when swallowing solid food. This pain is not felt below the level of the thyroid cartilage. There has been no bleeding. The pain is neither spontaneous nor lancinating, but occurs only during deglutition.

The patient is tall, poorly nourished and of pale cachectic appearance; has not decreased in weight; appetite good. Speech is thick and muffled, but not hoarse; breathing is at times slightly gasping, but he has felt no trouble whatever in this direction even after rapid walking or exertion.

Laryngoscopic examination reveals a large, deep, ragged ulcer with irregular surface in the glosso-epiglottic region. The ulceration extends anteriorly to the radix linguæ, posteriorly it occupies nearly the entire anterior surface of the epiglottis, with the exception of the narrow, swollen, red free lip. The ulceration extended downwards between the tongue and epiglottis, so that the latter appears loosely dissected and pressed well backwards, depending as a cover over the intritus laryngus. On casual examination it would appear that these are the lumen of the larynx felt with an ulcerating tumor, but by careful inspection the swollen free lip of the epiglottis can be seen posteriorly close to the pharyngeal wall. The lumen of the larynx itself can be definitely determined on account of the stiff immovable epiglottis.

The lymphatic glands in the region of the os hyoiseum are infiltrated, especially on the left side, and here they are also quite sensitive to pressure. The inguinal glands are also somewhat swollen. There are no other symptoms opening to a possible syphilitic infection. Further examination reveals nothing abnormal.

For three weeks he was treated with mercury and potassium iodide, which partially subdued the irritative redness about the outer zone of the ulceration, but the ulceration itself remained unchanged.

A TOOTH IN THE LEFT NASAL CAVITY CAUSING PURULENT RHINITIS.

BY HOMER DUPUY, A.M., M.D.

Assistant Surgeon Eye, Ear, Nose and Throat Hospital, New Orleans.

Medical literature has reached enormous proportions, and it is rare indeed when reporting a case that one cannot find the homologue to his own.

A careful review of the "Index Medicus," and of standard works and journals in rhinological literature, resulted in my finding the report of only one case of a tooth in the nasal cavity.

It is this knowledge of its rare occurrence and uniqueness, as well as its embryologic and pathologic features, which induced me to report the following case:

Mrs. H., aged twenty-five, presented herself at the clinic of the Eye, Ear, Nose and Throat Hospital for the relief of "Nasal Catarrh."

Patient stated that three months prior to her admission at the clinic she was thrown from her bicycle, falling on a hard, gravel-covered embankment.

Recovering from the shock she had a profuse hemorrhage from the left nasal cavity which lasted for over an hour.

About fifteen days after this accident she noticed a discharge from the left nostril, which gradually increased in quantity, and soon became very offensive.

From that time to the date of patient's admission in the hospital, a period of three months, the discharge continued uninterruptedly.

She insisted that on the occasion of her fall from the wheel a pebble had lodged in the nose, and was the cause of her present ailment.

While her nasal condition was a source of great discomfort, her general health seemed perfect. Rhinoscopic examination revealed pus along the floor of the left nasal cavity, which being removed, a body, having the gross appearances of a rhinolith, was seen on the floor of the nose, about half an inch from the anterior nasal orifice. A probe, used with considerable force, made no impression on the mass, which appeared to be deeply imbedded in the floor of the nose.

With nasal forceps the body was tightly grasped, and by dint of forcible and repeated movements, the mass was extracted.

To my surprise it proved to be a tooth, which on inspection showed the crown to be undergoing caries, the root, however, being perfectly normal.

A probe bent at a right angle, and passed along the floor of the nose, entered a socket having a depth of one-third of an inch. This was evidently the former seat of the tooth. The probe could neither be seen nor felt in the roof of the mouth, which presented no deviation from the normal.

The root of the tooth presented the typical outlines of an incisor.

The superior dental arch showed no break in its continuity; but on enumeration of the teeth, one was missing in the left half of the upper arch, and it proved to be the *left lateral incisor*. I emphasize the fact that this anomaly was not appreciable, except by enumeration of the teeth, which were so perfectly adjusted as to form an unbroken arch. The patient made a speedy recovery from the purulent rhinitis.

She reported at intervals for a period of six months, after which time examination of the nose showed the socket on the floor to have totally disappeared.

We are certainly not justified in presuming that this is the only instance of a *misplaced* tooth having erupted in the nasal cavity.

Nature repeats anomalies, time and again, yet, judging from the literature accessible to me, this particular anomaly has not often been recorded.

The scarcity of reports on so interesting a subject justifies my insertion of the one case I found reported.

In the June issue, 1899, of the *Southern California Practitioner*, Dr. Hoell Tyler, of Redlands, Cal., reports a case of "A tooth in the nasal cavity." I republish his article in full:

"The patient was thirty years old, and married. She sought treatment for catarrh and throat trouble and stated that she had been treated by several homeopathic specialists at intervals for several years. But having her nose sprayed, and taking medicine out of two glasses, had given but little relief.

"She had chronic rhinitis with a stinking discharge from the right nostril, chronic pharyngitis, and was anemic and in rather poor general health. On cleansing the nasal cavity I discovered what I mistook for a foreign body, about one inch from the anterior nasal orifice. I was surprised to find that I could make little or no impression upon it with forceps or strong steel hooks, although consid-

erable force was employed. Both ends being imbedded I determined to cut it in two by means of the dental drill and extract the fragments. The jarring of the drill loosened it somewhat and then with the steel hooks it was extracted.

"It grew from the nasal septum, in which it was imbedded to the depth of three-sixteenths of an inch, with the root turned downward. The root did not penetrate the roof of the mouth; it was not connected with the alveolar border nor with any cyst. The tooth extended horizontally directly across the nasal cavity, resting upon the floor of the latter and with its crown or point imbedded in the inferior turbinated bone. It resembles a canine tooth, is nine-sixteenths of an inch in length, a little over one-eighth of an inch in diameter in the largest part, had a pulp cavity and central canal and was supplied with blood vessels and a nerve. The patient had had the usual number of teeth in her jaws and there was nothing peculiar about her mouth.

"The wound in the nose healed readily and she recovered from the rhinitis and pharyngitis with ordinary treatment.

"Most of the works on surgery, and special treatises, speak of supernumerary and misplaced teeth sometimes forming cysts in the superior maxillary bone and occasionally penetrating the nasal cavities, but in the literature accessible to me I have been unable to find any account of a tooth growing from the nasal septum and I do not recollect having read a report of such an instance in the medical journals, although I have no doubt there are several such instances recorded."

REMARKS.

Dr. Tyler's case is evidently one of a *supernumerary* tooth; the one I report being a *misplaced* tooth.

The etiology of both anomalies is a most interesting problem, for which two explanations may be offered:

First—During the development of the embryo, the enamel-germ in both conditions being displaced from its normal position by some *intrinsic*, developmental force, inversion of the enamel-organ occurred, causing the tooth to grow upward.

Second—The same condition may have been produced by some *extrinsic* force, such as trauma or abnormal pressure, causing inversion of the enamel-organ in utero.

THE RADICAL TREATMENT OF FOLLICULAR TONSILLITIS.

BY M. A. GOLDSTEIN, M.D., ST. LOUIS, MO.

Among the various suggestions offered to aid prompt resolution of follicular tonsillitis are the advocates of radical measures who combine active local treatment with systemic medication. As the cause of infection may be traced directly to the tonsillar crypts with their contents of food detritus, micro-organisms and pus, and as the speediest means of arresting disease is to remove the cause, it is rational to conclude that complete evacuation and cleansing of these follicles of their infectious contents offers the speediest cure.

For this purpose I avail myself of two accessory instruments especially adapted to enter the follicles.

Fig. 1. Tonsil scoop.

The tonsil scoop here illustrated shows the natural size of the instrument. The curve in the shaft close to the curetting end facilitates the manipulation of the scoop about the follicles. The curette end consists of an oval, blunt, miniature spoon with a bowl sufficiently large to engage the entire contents of a single follicle with each introduction of the instrument. The shaft is about six inches long and of the same caliber at the proximal end as the shafts of the standard laryngeal mirror to admit of insertion in the universal handle.

An additional convenience in the applications of medications to the follicles after curettement is a flexible applicator, consisting of a nickel-plated soft copper wire with a tapering shaft, the end of which is faceted to securely hold a bit of twisted cotton. The flexible end of the applicator can be bent at any angle, and can also be made to penetrate the depth of a tonsil containing deep crypts and pockets.

The method which I have employed with best results is as follows: Each crypt or follicle is thoroughly cleansed with the tonsil scoop described above. Into each cleansed follicle the applicator, well armed with a small tuft of cotton saturated with pure guaiacol, is carefully introduced, precaution being taken not to spread the medication over the surface of the tonsil, but directly into the depth of the crypts.

Fig. 2. Flexible applicator.

I have also used protargol (ten per cent solution), trichloracetic acid (saturated aqueous solution) and Loeffler's solution in a similar way with equally favorable results.

These applications are to be made at intervals of eight hours, and if the cases are seen in the early stages of infection, but two, and, at most, three applications effect a cure.

The following gargle completes the local treatment:

℞ Liq. Ferri chlorid ..... ʒi
Glycerini ..... ʒi
M. S. Teaspoonful in glass of water. Gargle every two hours.

In addition to the local treatment I lay the greatest stress on three therapeutic factors: 1. A brisk purge, preferably produced by a saline draught, such as eight to sixteen ounces of magnesium citrate. 2. A good sweat as induced by pilocarpine hydrochlorate $^1/_{12}$ to $^1/_8$ grain, followed by wrapping the patient in blankets in bed. 3. Thorough saturation of the system with sodium benzoate and sodium salicylate.

SOCIETY PROCEEDINGS.

THE LARYNGOLOGICAL SOCIETY OF LONDON.

Eighth Annual General Meeting, January 5, 1900.

F. DE HAVILLAND HALL, M.D., President, in the Chair.

Case of Tabes with Almost Complete Laryngoplegia.

Shown by Sir Felix Semon. A. S., a carman, æt. forty years, was admitted under the care of Dr. Hughlings Jackson into the National Hospital on December 11, 1899. He had syphilis five years ago with secondary symptoms, and was treated only a few weeks. His present symptoms began fourteen months before admission with loss of control over the bladder. This was followed by numbness and shooting pains in the legs, trunk and hands, ataxia and gastric crises. For nine months his voice had been altering and he had had shortness of breath, but apparently no laryngeal crises.

Summary of Symptoms.—Extreme general emaciation. Arteries thickened and tortuous. Double ptosis. Reflex iridoplegia. Slight weakness of the right half of face. Extreme inco-ordination; marked hypotonia; can only walk when supported. Entire loss of sense of passive movement in lower extremities. Analgesia (partial) over face, over arms and upper part of chest and over lower extremities. Severe shooting pains and gastric crises. Complete incontinence of sphincters; no anal reflex. All deep reflexes absent; plantar reflexes show a typical tabetic response. No difficulty in swallowing, no return of fluids through the nose.

Voice.—Speaks in a loud, hoarse whisper. When talking he quickly runs short of breath, and between his utterances a sort of subdued inspiratory stridor is sometimes audible. He cannot cough in the usual way, but on attempting it a long, noisy expiration results.

Palate.—On attempted phonation the palate itself remains perfectly motionless, but the posterior arches make some rapid and feeble inward movements. The tactile sensibility is perfectly normal, but the reflex excitability is much diminished, though not completely abolished.

Larynx.—During quiet respiration both vocal cords stand perfectly motionless in about the minimum width of the cadaveric position (about 3 mm.) apart, but their posterior ends are a little nearer one another than is usual under such circumstances, and their free borders are not excavated, but perfectly straight. Neither on attempted deep inspiration nor on phonation is the slightest movement of the cords visible.

On touching the epiglottis with a probe, no reflex movement whatever is noticeable. On touching the inter-arytenoid fold regular closure of the glottis takes place immediately, without cough being produced.

On touching the right ventricular band reflex closure ensues. The same more strongly and combined with feeble cough ensues when the left ventricular band is touched.

Remarks.—The case is shown on account of its extreme rarity. It is the third case I have ever seen of complete or nearly complete bilateral recurrent paralysis, and the first I have ever seen in tabes. There is only, so far as I know, one case of complete bilateral recurrent paralysis in tabes on record. This has been described by Gerhardt.* Another very remarkable circumstance is the comparative loudness of the patient's voice. As a rule in bilateral recurrent paralysis the voice is entirely extinct and the whisper absolutely toneless. Finally, the manner in which a few fibres of the accessory and vagus have escaped (as shown by the fibrillary contraction of the palatinal muscles, by the possibility of closing the glottis on peripheral stimulation, by the maintained possibility of producing tension of the vocal cords through the crico-thyroids, and by the diminished, yet not quite abolished, reflex irritation of the palate and larynx) is very remarkable.

I have to thank Dr. Hughlings Jackson for kindly permitting me to show the case, and Dr. H. L. Collier for the notes of the general condition of the patient.

Mr. W. G. Spencer said that this was another instance of focal lesions in tabes, which agreed, in his opinion, with the results of experiments concerning the vagus group of nerves. The case pointed to a bilateral lesion of the nuclei corresponding to the pneumogastric roots, as shown by the sensory paralysis, the impairment of the respiratory muscles and the impossibility of coughing. Dr. Tilley and others had shown cases where the lower bulbar roots of the vagus were involved, in which, as distinct from the present case, there was noted paralysis of the abductors of the soft palate without loss of sensations in the larynx or disturbance of respiration, etc. There were also cases in which the spinal accessory nuclei were involved, and the trapezius and the sternomastoid muscles were paralyzed; in other cases the hypoglossal nucleus being also involved, there had been paralysis of one side of the tongue.

---

* "Bewegungsstorungen der Stimmbander," Nothnagel, *Spec. Pathologie und Therapie*, Bd. xiii, 1896.

Sir Felix Semon said that he did not wish to say anything at present as to the general question of the innervation of the larynx. This patient had not isolated abductor or adductor paralysis, but practically complete recurrent paralysis. If the patient attempted to cough, a large quantity of air escaped through the glottis, and this was the cause which prevented him coughing in the ordinary fashion. He was not aware that Dr. Tilley had ever shown a case of adductor paralysis in tabes, and doubted whether he had done so; cases of *ab*ductor paralysis in that affection, of course, were not rare. His reason for showing this case was that it was, so far as he knew, the second on record in the whole of the literature on the subject in which there was a *complete* laryngoplegia in a case of tabes dorsalis. As to the escape (?) of some fibers of the palate, he had pointed out in his paper this remarkable fact, both in the motor and sensory spheres, in the palate and larynx. The laryngoscopic image was not exactly as it would have been if the patient was suffering from complete paralysis of the superior laryngeal nerve, *i. e.*, the cords were not excavated but perfectly straight, which showed that the cricothyroid muscles must have escaped, a fact which was further corroborated by the comparative loudness of the patient's voice.

Case of Pharyngo-Esophageal Carcinoma.

Shown by Mr. Spencer. The patient is a man about sixty. He complains of wasting, owing to difficulty in swallowing during the last three months. He has a mass of carcinoma at the junction of the pharynx and esophagus and involving the back of the larynx, causing swelling of the arytenoids and ventricular bands, and there is also some infiltration of the glands in the neck.

Five other such cases have been seen during the past year. Two had very extensive infiltration of the glands in the neck, with some hoarseness and dysphagia. The primary growth was situated in the hyoid fossa, and quite small, not more than one to two cm. in diameter.

No attempts at removal have been made, as there seemed no prospect of affording relief, especially as the larynx itself would have to be removed. Neither would gastrostomy have improved the patient's condition.

All the cases have tended rapidly to a fatal issue.

Sir Felix Semon made some observations of a general character with regard to this case. Mr. Spencer had shown a case of early cancer of the *pharynx* in which the primary focus was very small, and yet there were big masses of glands in the neck. He asked,

Why did not the same happen in "intrinsic" cancer of the *larynx?* The school of Sappey was totally opposed to Luschka's statements on this question, according to which the laryngeal lymphatics were of a more isolated character than those of the pharynx, which freely anastomosed with neighboring lymphatics. Luschka's views had at any rate the merit of intelligibly explaining the undeniable clinical differences between intra-laryngeal and pharyngeal cancer with regard to infiltration of the neighboring lymphatics, which, if Sappey's statements were correct, was absolutely unintelligible. The speaker thought that this was a most important question, which deserved reinvestigation.

Case of Primary Atrophic Rhinitis Commencing in Infancy.

Shown by Mr. Spencer. A child, æt. five was brought for treatment on account of ozena and crusts. She has been for some time under Mr. Spencer, and has been treated by a saline douche without any marked improvement. The appearances in the nose are typical. There is an entire absence of any evidence that the rhinitis was secondary.

The child had nothing wrong with the nose during the earlier months of infancy, and she has had no other illness.

Dr. Bronner had seen several cases of ozena which had begun at an early age—twelve, indeed, between two and three years of age. They should make a distinction between atrophic rhinitis and ozena, which were distinct and separate diseases. In the north of England atrophic rhinitis was extremely common, especially amongst the mill girls. Ozena attacked its victim early, whilst atrophic rhinitis began between the ages of fourteen and eighteen. The cases of ozena he had seen in babies had been independent of syphilis; possibly, perhaps probably, they were connected with purulent discharge at birth caused by contagion. As regards the smell, the children of the working classes often smelt so badly that it would be difficult to detect the smell of ozena.

Dr. Herbert Tilley said he could find no evidence of congenital syphilis in this case. He had seen similar cases, and did not consider them very rare. It was interesting to find that no history of a purulent discharge preceded the present condition of scab formation, and therefore the case was opposed to Bosworth's view that atrophic rhinitis was a late stage of purulent rhinitis in childhood. The speaker thought the great majority of the latter cases were due to adenoids. Again, such cases as Spencer's showed how improbable it was that "ozena" arose from accessory sinus suppuration, as stated by Grünwald and others.

Dr. Jobson Horne suggested that bacterioscopic examinations made at intervals might possibly throw some light on the etiology of the condition.

Dr. Lambert Lack said he had seen a family in which several members among the children suffered from ozena, which commenced at an early age. He thought he could bring forward a dozen cases in which the discharge had commenced at as early an age as in the case under discussion. In the majority of these cases there was a history of purulent rhinitis at quite a young age, though it might not always be due to any special cause, such as gonorrhea, syphilis, etc. He believed that, as a rule, atrophic rhinitis was the result of long-continued purulent rhinitis; and that if one reckoned the discharge as an early symptom of atrophic rhinitis, the majority of cases could be dated back to an early period of life.

Mr. Waggett referred to a family case of atrophic rhinitis. The disease was well developed in the mother. Six years ago her daughter, six years of age, came to the hospital with muco-purulent catarrh. In spite of nose-washes, etc., she had gradually developed atrophic rhinitis, which was well established at the present date. Her younger sister had during the last two years exhibited the same sequence of changes. There was still another little sister, who was following the same course. Here was a case of family ozena quite unconnected with syphilis, and making itself evident between the ages of four and six.

Mr. Spencer, in reply, said the points in the case were that there was no evidence of congenital disease; the formation of crusts and the ozena had been first noticed at ten months. Atrophic rhinitis was very generally secondary, but in the present instance all inquiry as regards a secondary origin failed. He thought the related histories of affected families important in relation to a possible bacterial origin. Hitherto the bacteriology of the nose had not advanced far.

Case of Papillomatous Condition of Tongue.

Shown by Dr. Ball. A healthy-looking girl, æt. twenty, with good family history, has had discomfort in her tongue for about two years, and for the same period has noticed a "growth" on her tongue which has gradually increased in extent. The discomfort and soreness get worse for some weeks at a time, and then diminish, but never quite leave her. For the last few months she has felt some soreness of the throat on the right side. There is no history or suspicion of syphilis. Immediately to the right of the middle line of the dorsum of the tongue there is a marked outgrowth over an area

about half an inch broad, extending from near the tip to the origin of the circumvallate papillæ. It is made up of separate nodular masses varying in size from a grain of rice to a small pea. The surface is redder than the rest of the tongue, and the papillæ are enlarged. Under the tip of the tongue to the right of the frenum are some small warty growths. The right anterior pillar of the fauces is congested, and presents a few small glistening elevations.

Mr. Butlin said he had carefully examined the tongue, and believed that the disease should be described as a local macroglossia—an affection of the lymphatic system of the tongue. He had seen many similar cases, and this one resembled the first in which he had removed the disease. The patient was just such another red-faced country girl, and the tumor occupied the middle line of the tongue in two longitudinal crests. He thought they were papillary growths, and cut them out with scissors. The hemorrhage was very abundant, and continued to recur in so serious a manner that pressure had to be employed for part of two days before the bleeding was arrested. Ever since, Mr. Butlin had made a practice of cutting such growths out between the two deep incisions which passed far into the substance of the tongue. The edges of the incisions are brought together with silk sutures, and there is no fear of recurrent or secondary hemorrhage.

Specimen of a Bony Cyst or Middle Turbinate Bone.

Shown by Dr. Herbert Tilley. The specimen was a large bony cyst removed from the left middle turbinate of a young woman, æt. twenty-nine, who complained of nasal obstruction, aching over the root of the nose, and a constant discharge of clear fluid from the left nostril.

The cyst would contain a horse-beam, and was interesting from a pathological point of view. It contains a muco-purulent secretion and a few edematous granulations. It was removed by dividing the attachment of the middle turbinate to the outer wall of the nose with scissors, and then snaring the semi-detached portion.

The patient was quite relieved of her symptoms.

Dr. Watson Williams remarked that an ethmoidal cell sometimes existed normally in the middle turbinate body, and this, like the other ethmoidal cells, might become the seat of inflammatory disease. He thought it probable that in this specimen, as in many of the cases of cysts of the middle turbinate, some such "primary accessory sinusitis" arose, resulting in the blocking up of the ostium, and consequent distension with retention of secretion and formation of the cyst.

Dr. Jobson Horne inquired whether the cyst communicated with the interior of the middle turbinal body. He had met with what might be a somewhat similar condition, and in which he was inclined to regard the cyst as a modified anterior ethmoidal cell.

Dr. Bennett said these cysts were not rare, and in one or two cases, owing to pressure and pain, he had had to remove such at a comparatively early stage; there were no contents, but the space was lined with a perfectly smooth membrane. In one case he had to operate on account of the neuralgic pains. He did not understand how such cystic dilatations originate. He had seen larger cysts than those shown.

In reply, Dr. Tilley said that he had searched carefully for communication with the other ethmoid cells, but had found none. There was no evidence of accessory sinus suppuration. The exhibitor could offer no satisfactory solution as to the origin of such growths; they might possibly be a dilatation of the normal cells existing in the middle turbinate, which became enlarged as a part of a chronic inflammatory process; or, as MacDonald has suggested, they may arise from incurvation of the free margin of the bone enclosing a cavity lined with normal nasal mucous membrane as the result of an osteophytic periostitis.

Case of Male æt. Seventeen Years after Removal of Fibro-Myxoma of the Post-Nasal Region.

Shown by Dr. FitzGerald Powell. The case was shown at the last meeting of the society.

On December 2d he was placed under an anesthetic, and examination disclosed the extensive character of the tumor.

A preliminary laryngotomy was performed, and the upper aperture of the larynx plugged with sponges.

The soft palate was then split and the divined portions held apart by long silk threads passed through them. It was not necessary to remove any of the hard palate, as the posterior edge had been considerably eroded by the pressure of the growth. In this way the tumor was fully exposed, and was found to be attached to the body of the sphenoid. It fitted the whole of the naso-pharyngeal cavity, and sent prolongations into the right spheno-maxillary fossa and right nostril, pushing the septum against the external wall of the left nostril, and completely occluding it.

The bony walls of the naso-pharynx were considerably eroded by the growth. It was removed by the aid of "Lack's" snare and cold wire, and strong scissors curved on the flat, with which the toughest parts were dissected away.

The bleeding was severe, but was controlled by hot sponges and pressure.

The edges of the wound in the palate were brought together by silk sutures, and a sponge left in the post-nasal space for twenty-four hours and then removed.

The laryngotomy tube was allowed to remain in for three days.

The boy is now doing well, and returns home to-morrow. The wound in the palate has healed, but some of the stitches broke out, and there is still a small opening near its junction with the hard palate. This, though interfering somewhat with his speech, has the advantage of enabling us to observe the condition of the parts, and to treat the atrophic state of the naso-pharynx.

An operation at a future time may be attempted to close the wound and straighten the septum, or a suitable obturator may be worn.

The wound in the neck is quite healed, and gave no trouble.

The incontinence of urine and drowsiness from which the patient suffered has completely disappeared.

The tumor is a pure fibroma, dense and tough.

Mr. Butlin said the tumor was the largest he had ever seen taken from the naso-pharynx, and he thought it must have opened its way into one, if not both, of the antral cavities by absorption of the bone. It appeared more likely to be a fibroma than a sarcoma, and the operation bid fair to be a complete success. But he was afraid the hole in the palate was not likely to close.

Mr. Spencer had on the previous occasion expressed the opinion that the tumor belonged to the upper jaw, and should be operated upon through a facial wound. He thought that the case should be carefully watched, and if there were signs of renewed growth, this measure should be undertaken early. In a similar case the growth extended out into the spheno-maxillary fossa behind the antrum towards the temporo-malar and cheek region.

Dr. FitzGerald Powell in reply thanked Mr. Butlin and Mr. Spencer for the kind way in which they had alluded to his case.

He did not think that the growth had invaded the antrum, and he was quite certain it had not reached it from the nose, but it was possible that it had done so from behind, through the spheno-maxillary fossa. However, on the removal of the tumor, from its appearance and general contour he felt quite satisfied that he had got it all away. The prolongations of the growth, one into the nose and another which filled the pheno-maxillary fossa, were quite intact, and the growth itself was so tough and firm that it would have been impossible to break away any part of it without being able to recognize it.

There were two interesting points in connection with such tumors. The first was the difficulty in determining the extent and attachments of the tumor, and indeed the impossibility of doing so until the palate had been split and the growth exposed. The second was with regard to the diagnosis at an early stage.

This patient two years ago had been an in-patient at a London general hospital for six weeks, and was said to be suffering from a nevus of the throat (this was the history given by the boy's father), and he thought it was quite possible for such an error to be made at an early stage when frequent and serious bleedings were occurring.

Case of Intractable Aphonia with Occasional Apsithyria.

Shown by Dr. Pegler. A girl æt. twenty-two, a school teacher, had long been liable to temporary loss of voice on catching cold.

In February, 1899, she suddenly lost it altogether and, except for a slight recovery in response to a local galvanic application by the family doctor, had since been not only unable to speak, but often could not even whisper, and in the months of July and August following had either carried a conversation book about with her, or had communicated with her friends on her fingers. She came as an out-patient to the Metropolitan Throat Hospital in November. On examining the larynx a stammering action of the vocal cords was all that could be seen on attempted phonation, but the stimulus induced by probing the larynx in any situation was sufficient to create adduction and production of tone. The laryngeal electrode was applied to the vocal cords systematically about three times a week for a month, resulting in considerable improvement. The glottic chink was then elliptical, the internal thyro-arytenoid being mainly affected. More latterly much of the improvement fell off, the arytenoid muscle became also paretic, causing the triangular glottis, and the girl had on more than one occasion become apsithyric again, so that there was distinct retrogression, and the usual treatment having so far failed, fresh suggestions were invited from the society. The family history was noteworthy. Paternal grandfather epileptic; mother liable during her pregnancies to violent fits of hysteria. Two brothers, out of a family of six living, were epileptics. Patient herself had shown no other manifestations of hysteria.

Dr. Herbert Tilley gave details of a case of an inveterate nature in which very strong intra-laryngeal faradic shocks produced no result whatever, not even temporary improvement, neither had any other sudden painful shock been of avail, and he asked Sir Felix

Semon if he knew of any successful means of treating such cases. In the case referred to by the speaker, the latter advised isolation, Weir Mitchell treatment, and then when the system was in a healthy condition the application of the strong faradic current.

Dr. Bennett suggested that breathing exercises should be tried. He had recently, after two or three years of trouble with a patient who had been to several hospitals, tried these exercises systematically; the voice after a short time completely returned. No other treatment, such as faradisation, etc., had done any good. The patient had now been several months without return of aphonia. He should say that in the case under discussion the upper-chest breathing was very bad; in fact, her whole method of breathing was irrational.

Dr. Bronner recommended the trial of the faradic current with the metal brush. It was extremely painful, but most useful. He had treated a servant some months ago who had been aphonic for several months, and in fact was about to be dismissed; he tried the above treatment, and she was cured almost immediately.

Sir Felix Semon looked upon cases such as had been mentioned in the discussion, in which, apart from the aphonia, there was functional paralysis of the whole apparatus of articulation, including the movement of the lips, as examples of Charcot's "hysterical mutism;" they represented, as it were, the superlative of hysterical aphonia. In reply to Dr.. Pegler's question, he stated that in his experience the vast majority of cases of hysterical aphonia could be cured in one sitting by intra-laryngeal applications of electricity, one electrode being applied to the inter-arytenoid fold, and he wished to repeat this statement emphatically, in spite of the fact that this experience of his had been recently queried in a text-book. But it was necessary to exercise very considerable energy in many of these cases. With increasing experience, he had become more and more convinced that, added to the physical inability, there was in many of these cases considerable mental perversion. When after restoration of the voice by electricity, as manifested by the involuntary cry which usually was the first sign of the restored function of the adductors, the patients were directed to use their voice, as in counting from one to ten, or as in replying to questions, many of them did not make the least effort, and showed themselves as wilfully obstinate as possible. He always insisted, in view of this mental perversion, and of the danger of one's therapeutic efforts being afterwards misrepresented to the patient's friends, that a friend—or, if possible, the patient's general medical

attendant—should be present when intra-laryngeal faradisation was applied. He instanced one case, occuring in Dr. Playfair's practice, of the very worst form of general hysteria, in which intra-laryngeal faradisation, sufficiently strong and sufficiently long-continued, had succeeded in restoring the voice in the first sitting, but only after very severe applications, and emphasized the necessity of persevering with one's efforts until this result had been obtained. Failure in the first sitting almost always meant the patient's non-reappearance for the second. Whilst thus extolling the effects of intra-laryngeal faradisation, he wished to state that a few of his cases had remained rebellious to it, and to every other form of treatment recommended, such as hypnotism, articulation exercises, use of internal remedies, change of air and residence, attempting to make the patient speak loudly when awaking from chloroform narcosis, etc. In one such case the voice had been restored by the unexpected application of a cold water douche; in others, this remedy too had failed. He particularly remembered the case of a major in the army, a strong, powerful man, and the very last whom one would expect to become a victim to hysterical aphonia. This patient assiduously tried everything that was suggested, because loss of his voice of course meant professional ruin to him; however, everything failed. Fortunately, however, in this case, as in all other rebellious cases known to him personally in which medical art had failed, the voice one day without any external cause returned as suddenly as it had disappeared. With reference to Dr. Tilley's question, whether local treatment was likely to be more successful after a previous course of Weir Mitchell's treatment, he could not answer it, having had no experience with regard to this special point. Finally, with regard to a question of Dr. Pegler's asking which laryngeal muscles were chiefly affected by hysteria, Sir Felix said that ordinarily, in his opinion, the whole group of adductors were concerned. In cases in which the inter-arytenoid muscle only was affected, with the well-known laryngoscopic image of a small triangular opening in the hindermost part of the glottis, the prognosis in his experience was not nearly so good; but then he thought in a good many of these cases the paralysis was not merely functional, but that the small inter-arytenoid muscle had actually undergone trophic changes, and some of these cases in his experience had permanently resisted every form of treatment, and had remained uncured.

In reply, Dr. Pegler said that the patient being always accompanied by friends, the latter had been often able to judge of the

comparative facility with which the voice could be coaxed back by a probe or electrode in the larynx. The faulty breathing was most apparent; the chest muscles also seemed to stammer in a certain sense, and she could only count some six figures before requiring to take a fresh breath. The spirometric reading was 50 per cent below par, and the patient was under special treatment and in expert hands for that defect. Every precaution had been taken to allow the muscles of respiration free play by wearing suitable clothing in place of the old-fashioned tight corsets.

Case of Naso-Pharyngeal Growth (? Sarcoma).

Shown by Dr. Pegler. A man, æt. twenty-seven, complaining of complete inability to breathe through his nose for four years, and occasional profuse attacks of nose-bleeding on making the attempt. This case had some interest through having first come under observation at the Metropolitan Throat Hospital about two and a half years ago. when the following note was made: "On digital exploration of the naso-pharynx a soft polypoid mass is felt, much like adenoids, dependent from the roof and posterior wall, chiefly to the left of mesial line. Being easily detached, two fleshy masses were expelled, one from each nostril, and the breathing became quite free. Sections of the material consisted of small-celled apparently lymphoid tissue." The patient did not return to the hospital till January, 1900, and the nasal obstruction was then absolute. Inspection from the front showed a dark, softish, vascular and brittle growth in the right nasal chamber, which space it was expanding posteriorly. In the left naris the septal mucous membrane was turgid, and freely bled on the least touch. In the naso-pharynx a large lobulated mass could be felt depending from the roof. The free edge of the septum was difficult to reach owing to its absorption. A piece of the mass was snared off, and sections shown under the microscope displayed mixed cells—small, round, and spindle, with no structural disposition. Lymphoid follicles and gland-cells were absent.

Dr. Herbert Tilley said he had made a digital examination, and found a soft vascular growth occupying the post-nasal space and spreading forwards into the nose; the posterior portion of the vomer had also been destroyed, and he thought it high time to proceed with the radical operation, after first splitting the soft palate and performing a preliminary tracheotomy. This course had also been suggested by Mr. Butlin.

THE LARYNGOLOGICAL SOCIETY OF LONDON.

Fifty-Fifth Ordinary Meeting, February 3, 1900.

F. DE HAVILLAND HALL, M.D., President, in the Chair.

A report from the Morbid Growths Committee was read by the secretary. The committee reported that sections made from tissue handed to them by Dr. Cresswell Baber from his case of nasal tumor (see *Proceedings* for June, 1899, page 109) showed no evidence of malignant disease. They also reported that the tumor of the ventricular band shown by Dr. Furniss Potter (see *Proceedings* for November, 1899, was a fibro-angioma.

The following cases and specimens were shown:

A Case of Complete Fixation of the Left Vocal Cord.

Shown by Mr. Wyatt Wingrave. A girl æt. nineteen, born and until lately resident in India, complained of weakness in her singing voice and huskiness in her speaking voice, of gradual onset, about four months ago. There was also some dyspnea on exertion and singing. She had always been somewhat pale.

When first seen, about a fortnight ago, the left vocal cord was fixed in the cadaveric position, its texture and color with the rest of the larynx being normal.

There was no definite evidence of organic interference with the recurrent laryngeal, neither was there any history or collateral sign of local inflammation or hysteria.

She was ordered complete rest from singing and nerve tonics.

The President said that evidently the condition had altered lately, as the cord was now fairly moveable. Such cases of paresis were generally the result of some neuritis, and he thought this case probably had a similar origin.

Mr. Wyatt Wingrave said it was very gratifying to find that the cord was now moving. The case was interesting because only one cord was involved and that one the left.

An Unusual Form of Ulceration of the Throat in a Patient the Subject of Syphilis.

Shown by Mr. Wyatt Wingrave. A male, æt. twenty-five, was first seen on January 16th last, when he complained of pain in the throat and inability to make his teeth meet, of four months' duration and gradual onset.

A deep, ragged ulcer with fleshy projections was seen in the right post-molar fornix, from which a firm edema extended to the whole of the soft palate and uvula; in appearance it was translucent, with milky patches. Movement of the manible was painful, and the incisors did not meet by a quarter of an inch. Deglutition was difficult but painless. The submandibular and supra-clavicular lymphatic glands were thickened. The patient was very anemic, and complained of great weakness and loss of flesh.

There was a history of syphilis five years ago, also of renal colic twelve months ago. His wisdom teeth were present.

He was at once ordered potass. iodid. and bichloride of mercury.

The edema is considerably reduced. He is free from pain, and can now masticate without much difficulty.

The appearance and physical character were at first somewhat suggestive of malignancy (sarcoma), but so far the result of treatment points to syphilis.

The President said this case reminded him of a similar one under his care at Westminster Hospital, which also had a history of syphilis —a man with gumma in the throat. He improved under large doses of iodide of potassium, and was discharged as cured. About a year later he came again with the same complaint, and again improved on the same treatment and was discharged. A few months later he was admitted a third time, and on this occasion iodide of potassium had little or no effect upon him, and eventually he died of malignant disease. At the commencement he thonght his diagnosis of syphilis had been confirmed by the good results obtained from treatment by potass. iodid.

Case of Nasal Polypi with Suppuration and (?) Absence of Maxillary Sinuses.

Shown by Dr. Lambert Lack. The patient, a man æt. twenty-eight, came under my care complaining of nasal obstruction and purulent discharge, with a disagreeable odor in the nose. The polypi having been removed, the pus appeared to flow from under the anterior ends of the middle turbinates. After wiping the discharge

away and bending the patient's head forward it reappeared in large quantity. On transillumination the cheek on both sides appeared quite dark, and the patient had no subjective sensation of light. The diagnosis of antral suppuration was now considered almost certain, and the patient was advised to have both antra punctured from the alveolar margins. This was accordingly attempted under gas, but although the antrum drill was forced in for its full length no cavity was reached. I next attempted puncture from the inferior meatus of the nose, and used considerable force in two different spots, but with no better result. It seems, therefore, that the antra must be very small, if not entirely absent. The case is a somewhat embarrassing one, as the patient is naturally disappointed. I have brought him forward as a very rare—in my experience an unique—case, and I should be glad to know if any members have had similar experiences.

Mr. Spencer suggested, in the absence of any evidence of a collection of pus in the frontal sinus, that the best method of treatment would be to remove the inferior turbinal on the left side. It must be one of those convoluted turbinals which form a gutter in which pus collects. He had seen such a case. With regard to the osseous condition of the nose, he had seen a man in which this condition was much more marked than in the case under discussion. On tackling the nose, he started with the idea of doing what he advised here, inferior turbinectomy under an anesthetic, but there was so much bony thickening of the outer wall of the nose that he had to bore his way right back to the naso-pharynx until he could pass his finger through the nose. A good deal of hemorrhage resulted, and plugging had to be resorted to. This young man, who had had a swelling for several years, was now in a most satisfactory condition.

Dr. Pegler could see no justification for any interference with the inferior turbinal body. He inquired if the cavity of the antrum had been explored by means of Krause's opening. He had no doubt that Dr. Lack would remove the diseased portion of the middle turbinal from which some polypus buds could be seen sprouting, after which the source of the pus might perhaps be more easily traced.

Dr. Herbert Tilley thought it probable that there was a small antrum on one or both sides, and reminded those present of Ziem's paper on antral suppuration read before the British Medical Association when last held in London. He then pointed out that the antrum may be represented by a mere dehiscence in the bone. The speaker questioned the probability of an antrum so small as that producing so much suppuration as in Dr. Lack's case; possibly ethmoidal disease was present also. He (Dr. Tilley) had just experienced a

similar difficulty in finding an antrum situated high up in the maxillary bone, the perforator entering one and three-quarter inches before striking the pus. He should advise in Dr. Lack's case removal of the anterior half of the middle turbinate, and exploration of the antrum from the middle meatal region, if necessary making a large opening into it in this position. He had recently operated upon a young man in whom the naso-antral wall in the inferior meatus was so thick that the heads of two strong burrs had been broken off in the attempt to enter the antrum in this position, consequently the operation undertaken for exploration of the antral cavity developed into one for removing foreign bodies from the nose.

Dr. Scanes Spicer, understanding that there had been polypi and suppuration on both sides, thought the probable explanation of this case was that a traumatism had deflected the septum and initiated inflammatory changes in the middle turbinals. The left nose was now almost functionless, from the approximation of the septum and inferior turbinal combined with alar collapse, and the right nose had to do a double share of work, a state of affairs which tended to maintain congestion, suppuration, and recurrence of polypus in the middle turbinals. From the cursory examination then alone possible and the history given, he thought the ethmoidal disease sufficient to account for the symptoms and course of the case, without assuming that the antra (which were doubtless small) were suppurating.

Dr. Lambert Lack, in reply, said that he agreed that it was a case of ethmoidal disease. He had brought the case forward because of the remarkable way in which it had simulated antral suppuration, and because of the failure of the attempts to perforate the antrum. The fact that the cheek was opaque on transillumination was explained by the osseous condition. He could not insert a trocar in any direction. He thought there was probably suppuration in the ethmoidal cells, and he intended to remove part of the middle turbinate and open some of these cells, and he would also at the same time endeavor to open the antrum from the middle meatus as Dr. Tilley suggested.

Case of Pachydermia Laryngis.

Shown by Dr. Jobson Horne. The patient, a married woman æt. twenty-three, had been troubled with hoarseness and dryness of the throat for nearly two years. Aphonia had developed gradually two years previously, during her first pregnancy, and she had reached the sixth month of another pregnancy.

Both ventricular bands were considerably thickened, with little or no edema. The left band presented a longitudinal grooving on its inner aspect, and into this there passed during phonation a wedge-shaped excrescence of the right band. The free edge of the epiglottis was a little rounded. The cords themselves, though partially obscured to view, moved freely and appeared natural, and so did the arytenoid and inter-arytenoid regions.

The examination of the thorax yielded no signs of tuberculosis, nor was there any family or personal history suggesting tuberculosis; but the sputum had not been obtainable for examination.

There was also to be noted some chronic pharyngitis and atrophic rhinitis.

Dr. Jobson Horne was inclined to regard the case as one of pachydermia laryngis, but what had given rise to the condition was not at present very clear.

Dr. Dundas Grant thought from the appearance of the larynx that it was a tubercular pachydermia, and that it was not primary but secondary to tubercular disease. Perhaps Dr. Horne would bring the case before the society on a future occasion.

Dr. Scanes Spicer also thought this case was one of a chronic tubercular laryngitis, the mass of growth being on one side only, extending the anterior two-thirds of the cord, and there being no protuberance corresponding cupping over the opposed vocal processes.

Case of Laryngeal Affection in a Tubercular Patient for Diagnosis.

Shown by Dr. Cathcart. The patient, a male æt. twenty-six, unmarried, came under my care at the London Throat Hospital last week. He complained of chronic hoarseness, which began at the end of September, 1899. The family history is good, except that two brothers have died of consumption. For some months prior to July, 1899, patient had been losing weight and spitting blood. He had no night-sweats, and only a slight cough. At that time tubercle bacilli were found in the sputum.

During August he went for a holiday, and gained weight slightly, and also ceased to spit blood. In the beginning of September the sputum was again examined, but no tubercle bacilli were found. At the end of September he began to get hoarse, and has been getting gradually worse. His general condition at present is better than it has been for some time. He is not losing weight or spitting blood, and has a very good appetite. When his larynx was examined last week it was found to be very irritable, red and inflamed; the cords

were red and thickened. There was no swelling at the posterior part or over the arytenoid cartilages, but there was a slight uniform swelling below the anterior commissure. I shall be glad to have the opinion of the members on the case.

Dr. Clifford Beale would be rather inclined to describe the condition as one of simple irritation due to a local cause, which in this case was obviously subglottic. He did not think that the appearance was characteristic of tubercle. It was a matter of common observation that mucus might collect and remain for a long time in the anterior commissure of the cords, and he had watched cases for several weeks in which such collections of mucus were always present. Dried and decomposing mucus was apt to give rise to irritation if undisturbed by coughing, and he thought that the subglottic swelling in this case had probably arisen in this way. Infection of such irritated areas by tubercular mucus from below was always likely to happen, and hence he should always advise early treatment by removal of such mucus with a mild astringent.

The President said the condition of the larynx reminded him of that seen after tracheotomy, where the irritation of the tube had caused growth of granulation tissue below the vocal cord; he would agree with the views of the previous speaker.

Dr. J. Dundas Grant said the appearance reminded him of cases he had dissected of laryngeal and pulmonary tuberculosis, in which there were shallow oval ulcers on the mucous membrane of the trachea. The fact that the patient had evidence of tubercular disease made it only natural to suppose that the appearance in the trachea was due to tubercular disease.

Dr. Cathcart said that the opinion of the majority of the members was that the ulceration was tuberculous. Several had suggested that it was perhaps syphilitic, but on questioning the man no trace of a syphilitic history could be found. The septum had been examined that day, but there were no tubercle bacilli present. He intended to treat the case as one of a tuberculous nature.

Case of Bulbar Paralysis.

Shown by Mr. Waggett. A man æt. sixty-one, of temperate habit, and denying syphilis, presented the condition of progressive muscular atrophy, involving the region of the bulbar innervation as well as other parts.

Symptoms commenced in the spring of 1899 with difficulty in swallowing, lisping speech, and wasting and paresis of the hand muscles. Later cramps had been experienced in the legs and inability to walk securely.

At the present time there was paresis of the lips; atrophy, tremor, and paresis of the tongue. Paresis of the palate more marked on the left side, and causing escape of air through the nose during speech. The most marked symptom was great and increasing difficulty in swallowing. This symptom had slightly decreased since galvanism had been emyloyed. On one occasion temporary diplopia and a fluttering in the ear had suggested a recent spread upwards of the nuclear degeneration.

With regard to the larynx, when first seen a fortnight ago there was fixation of the left cord in the middle line, with abductor paresis of the right cord. At the present time there was marked abductor paresis on both sides.

The question of tracheotomy was raised, and experienced opinion was sought as to the real value of galvanism in the treatment of the pharyngeal paresis.

The President said he had experienced great difficulty in diagnosing a case of commencing bulbar paralysis where there was no impairment of the movement of the tongue. The patient was brought to him on account of the attacks of severe dyspnea. On examining the vocal cords he found some paresis of the abductors, with a certain amount of adductor spasm.

Dr. Dundas Grant said that the general features of the case confirmed Mr. Waggett's opinion that it was part of a general muscular atrophy, or anterior poliomyelitis, the first interossei and trapezius muscles having almost completely gone.

Sir Felix Semon, in reply to Mr. Wagget's question, said that in the early stages of bulbar paralysis methodical use of the constant current sometimes greatly improved the patient's swallowing. He had had several cases which had so improved.

The President added that his case had improved under the use of galvanism.

Case of Thyrotomy for Tertiary Syphilitic Laryngitis.

Shown by Mr. Spencer. A man æt. thirty, on whom he had performed thyrotomy three months before. A quantity of very tough fibrous tissue was removed, along with a portion of the right vocal cord.

The man had been under observation for a year, and the laryngeal stenosis had gradually increased in spite of full doses of iodide and mercury, until he had dangerous dyspnea at night.

The choice of treatment then lay between thyrotomy and tracheotomy. The former had been selected because the larynx was al-

ready filled with such masses that no voice could have been anticipated after tracheotomy. Moreover, in a former almost identical case, in which he had done tracheotomy, the patient when drunk got his tube out, could not replace it, and was asphyxiated very quickly.

At present the patient could breathe well at night, and had gone back to work. He had at present only a loud hoarse whisper.

There had been some recurrence, but the patient had returned, and was again taking iodide in forty-grain doses.

The President said from their experience it was difficult to say what was the best thing to be done. This case looked as if it were contracting again and tracheotomy would be required. He had had a distressing case in which tracheotomy was done; the growth continued into the trachea, and tracheal stenosis resulted in spite of potass. iodid. The patient went to several London surgeons, but there was nothing to be done. He then went to Paris, and died on the operating table. The President asked all members to bring such cases before the Society, that they might solve the question as to the best mode of treatment by the consideration of a series of cases.

Case of Ulceration of the Pharynx for Diagnosis.

Shown by Dr. StClair Thomson. The patient, a man æt. sixty-four, has complained of sore throat for three months. There is no history of syphilis. When first seen the left tonsil was covered by a "wash leather" slough, which also extended slightly on to the soft palate and anterior pillar of the fauces. On examination with the mirror the same condition was observed passing down nearly as far as the pyriform fossa. Some days later the slough separated and showed an ulcer with raised edges and somewhat hard on digital examination. There is no glandular enlargement.

Sir Felix Semon said there could be little doubt as to the malignant nature of the ulcer.

Dr. Tilley said the hardness of the growth confirmed the view just mentioned.

Cleft Soft Palate and Well-marked Post-Nasal Adenoids.

A case of a boy æt. thirteen, with cleft soft palate and well-marked post-nasal adenoids, was also shown by Dr. StClair Thomson.

At a special meeting held February 3d, at 4:30 p. m., for the purpose of discussing the question, it was proposed by Dr. Scanes Spicer, seconded by Sir Felix Semon, and carried unanimously: "That it was desirable that at all International Congresses there should be full and separate sections for Laryngology and Otology."

NEW YORK ACADEMY OF MEDICINE.

SECTION ON LARYNGOLOGY AND RHINOLOGY.

Stated Meeting, February 28, 1900.

Wendell C. Phillips, M.D., Chairman.

Paralysis of the Left Vocal Cord.

Dr. Joseph A. Kenefick exhibited a man having paralysis of the left vocal cord. He gave a history of syphilitic infection twenty-five years ago. The pupils were unequal and he experienced difficulty in swallowing. There was an expansive pulsation over the pericardium and unequal radial pulses. A probable diagnosis had been made of aneurism of the aorta pressing on the recurrent laryngeal nerve.

Dr. Francis J. Quinlan said that he had now under observation a somewhat similar case, namely, aneurism of aortic arch, an interesting feature of which was the "tugging" on the larynx.

Angioma of Posterior Pillar.

Dr. Talbot R. Chambers, of Jersey City, presented a boy of sixteen who, three years ago, had been injured by a stick running into his throat. One year later something had been discovered in the throat, and recently there had been difficulty in swallowing. Examination showed a bluish tumor on the anterior aspect of one of the posterior pillars. It measured 1½ by 1 by ¾ inches. He purposed to remove this growth with the hot snare under chloroform anesthesia. He looked upon it as an angioma. Having had some experience with this class of tumors, he was not so afraid of operating on them as he would have been simply from looking at the structure of such a tumor. He had recently removed an angioma of the orbit and optic nerve, and had not experienced any unusual hemorrhage. In the case presented he feared there would be a good deal of bleeding because of the softness of the tissues.

Dr. Wendell C. Phillips said that eight or ten years ago he had reported a case of very large angioma of the uvula. That patient always maintained that the growth had developed shortly after taking a poisonous dose of aconite. In that instance he had removed the growth with the galvano-cautery loop, and much to the surprise of every one present there had been almost no hemorrhage. The man had recovered perfectly, and had had no recurrence so far as known.

Dr. Jonathan Wright said that such growths were very rare in this situation. He had seen one of them situated at the base of the tongue and hidden in a mass of lymphoid tissue. He had had this woman under observation for three or four years, and had not been able to observe much increase in its size. As the growth had given rise to almost no symptoms, he had not felt disposed to remove it. Of course, if the loop were applied close to the base there would not be much hemorrhage, but if, in sessile tumors, the grasp were made at some distance from the base there was apt to be very profuse hemorrhage.

Dr. M. D. Lederman said that digital examination of this growth revealed no pulsation. The superior portion of the mass seemed to involve the tonsillar tissue. He recalled a case of a female, thirty-five years of age, with a history of coarse voice. Examination showed a reddish growth on the anterior third of the left vocal cord. The mass was removed with the ordinary laryngeal forceps, under cocaine, and though the patient coughed up a little blood at the time of the operation, no further trouble was experienced. Macroscopically the tissue appeared to be angiomatous in character.

Dr. James F. McKernon said that he had operated upon an angioma of the naso-pharynx about one year and a half ago. It was situated behind the soft palate, to the left of the median line. He had attempted to remove it with the galvano-cautery snare, and had succeeded, but there had followed a free and persistent hemorrhage. After repeated packings he had attempted suturing, but the latter had been impracticable until he had split the soft palate. A catgut of medium size had been used, and then the palate had been sutured with iron-dyed silk. About five months ago he had seen an angioma in a case in which there had been such profuse secondary hemorrhage that it had seemed almost necessary to resort to saline infusion. It had been necessary to keep up the packing in this case for a week.

Papilloma of the Vocal Cord.

Dr. Francis J. Quinlan presented a woman, about forty-five years, whom he had first seen about one week ago. Examination had shown a new growth of a waxy appearance, and occurring without infiltration of the glands, soreness or hemorrhage. According to the history, the hoarseness commenced about six months ago and set in after a spell of coughing. The growth resembled the ordinary papilloma, but differed in color. It occupied the anterior two-thirds of the right cord.

Alarming Hemorrhage Following the Removal of the Tonsil.

Dr. Quinlan then narrated a case in which there had been an alarming hemorrhage after excision of the tonsil. It had occurred in his hospital service. After two or three hours hemorrhage had suddenly set in and was very profuse, not yielding to the ordinary measures or even to the use of the suprarenal extract. The man had become so blanched that saline infusion had been resorted to. There had been no difficulty in getting out the tonsil, which was a small one, and examination of the mass showed no anomalies of the blood supply. The man had remained in bed after the operation and was there at the time the hemorrhage occurred. Dr. Butt's instrument for making compression was not at hand at the time, and therefore had not been tried, but he was skeptical about such an instrument proving very satisfactory in a large proportion of cases, as the point of bleeding must be ascertained and direct pressure maintained until organization of the clot was established.

Dr. Lederman spoke of a case upon which he had operated. It was the largest tonsil that he had ever removed, and the operation had been done with the galvano-cautery. Five days after operation the patient had swallowed a piece of toast, and this had carried away the eschar, with the result that such a severe hemorrhage had occurred as to demand a hasty summoning of the nearest physician. Cocaine was sprayed upon the part, and the hemorrhage had then stopped, but it had recurred later and had been checked by the application of a solution of alum and ice. Large blood clots had formed, but with careful manipulation these were removed without much secondary bleeding. The history of the case was mentioned as a warning to emphasize the importance of the after treatment in these cases. This hemorrhage occurred five days after the removal of the tonsil, though no blood was seen at the time of operation. Careful directions as to the consistency of the food should be given, especially when the cauterized tonsillar surface has been rather extensive. Have also seen annoying bleeding follow after the removal of the eschar from the inferior turbinals. It is judicious to practice "masterly inactivity" after such cauterizations.

Dr. McKernon spoke of a case that had been presented at the last meeting. It had been operated upon since that time, and the growth found to involve almost the entire lower portion of the larynx, the esophagus and the pharynx. Tracheotomy had been done two days prior to operation. Five days after the operation pneumonia had set in, yet, strange to say, the patient had recovered.

Secondary Hemorrhage Following the Use of the Suprarenal Extract in Intra-Nasal Surgery.

Dr. F. E. Hopkins, of Springfield, Mass., read a paper on this topic. He said that after having used the suprarenal extract for some time he had become so enthusiastic over it that he had found it difficult to charge anything against this new remedy, but he had been compelled to take cognizance of a tendency to secondary hemorrhage, coming on from two to six hours after operation. The first case had been that of a young woman from whom he had removod a posterior exostosis of the septum under the combined effect of cocaine and suprarenal extract. Hemorrhage had occurred three hours later. He had occasionally observed in patients an idiosyncrasy to its use, violent coryza sometimes developing after its application to the mucous membrane. Sometimes its use would be followed by sneezing, lasting for hours. From numerous inquiries, made among his friends and among representative laryngologists, it was evident that the concensus of opinion indicated that there was an increased tendency to secondary hemorrhage after the use of suprarenal extract. In two cases following its use the hemorrhage was alarming. Dr. Hopkins said that he had used the extract in a number of acute and subacute inflammations of the upper-air passages, and almost always with satisfaction. The final relaxation following the combined use of both cocaine and suprarenal extract was found to be greater than after the use of cocaine alone.

Dr. Hopkins thought one had no right to speak of percentages in regard to solutions of the suprarenal extract, because the quantity actually dissolved was not known.

Dr. Jonathan Wright said that it had always seemed to him that the profound contraction of the vessels resulting from spraying the extract into the nasal passages should favor an undue relaxation subsequently and consequently conduce to hemorrhage. He had, therefore, adopted the plan of smearing the powder only on the field of operation, using a moistened probe for this purpose. The same reasoning would apply to cocaine, and here also he preferred to use a pledget of cotton to a spray. He had used the extract in half a dozen cases of adenoids with no untoward results. (In adults without ether.)

Dr. W. H. Bates said that a physiologist who had been studying the properties of suprarenal extract, Dr. Cleghorn, of Hartford, had recently written to him that there was good reason for believing that the action of the extract was upon the muscle directly, and not upon

the nerve at all. This investigator had found that the suprarenal extract was the most potent agent known for stimulating the action of the heart, and the same result had been obtained when a part of the heart was experimented on which was devoid of nerves. When the extract was injected intravenously, the blood pressure rose considerably, but this was not followed by a fall, showing that there was no subsequent dilatation of the vessels. If these physiological experiments were trustworthy, there would not be any greater tendency to secondary hemorrhage after its use than where it was not employed at all. When operating on the nose, he personally expected secondary hemorrhage. His own experience in nose and throat work had been that there was less secondary hemorrhage with the suprarenal extract than where it had not been used.

Dr. Lederman cited a case in which he had endeavored to relieve an acute coryza, in a professional friend, by means of an insufflation of the very finely powdered extract. Sneezing had come on immediately and had lasted all that night. There had been, during this time, a continuous discharge of a watery fluid from the nose, and the body temperature had risen to 101°F. An application of a *solution* of the extract on the previous day had not caused this irritation. His own custom, in intra-nasal surgery, was to introduce a piece of spunk over the wound impregnated with some antiseptic powder, as nosophen, and remove the plug the following day. The advantage of the spunk, is that no secondary bleeding follows its removal, as no "sticking" to the wound occurs, which so frequently happens when cotton or gauze is employed even if covered with some oily product.

Dr. Emil Mayer said that for the purpose of comparison he would take cocaine. All agree as to its wonderful help to us and yet it has its limitations and there are many of us who have passed uncomfortable hours because of its use. So, therefore, in regard to suprarenal extract, we have no right to speak solely of its great value without remembering that there are instances where it may be harmful. He could not state too emphatically his belief that in the operations for adenoids and tonsils the suprarenal extract should not be employed under any circumstances, because of the danger of secondary hemorrhage. In the speaker's opinion it was better to have whatever loss of blood there was to be at the time of operation when he was there to control it if need be, than to have it occur some hours later when skilled help might be hard to find.

It had always been his custom to pack the nostril after operations and this precaution was followed when the suprarenals were employed. Nevertheless he had seen more cases of secondary hemor-

rhage when the extract had been used. It was also noticeable that it took a longer time for the blood to cease to appear in the discharges.

A case was cited in which the suprarenal extract was employed and the secondary hemorrhage having been profuse, the subsequent oozing lasting for many days, so the other side was operated on under cocaine alone. There was very little bleeding and in two days the discharges were free from blood. He did not wish to be understood as being hypercritical, for the action of the extract was really wonderful, but he wished to emphasize that it had its limitations. It was perfectly natural that when the muscular coats of the arteries contracted so as to produce the ischemic effect, they must dilate again before final contraction. In this dilatation with relaxation of the muscles lay the danger. In the nose we were usually able to reach the bleeding part, but in the pharynx or naso-pharynx hemorrhage serious consequences might result.

Dr. W. Kelly Simpson said that he had removed a very large adenoid under the suprarenal extract, and without any unpleasant consequences. He did not think it was possible to use a solution of this extract in an atomizer, without filtration. The remedy had the great advantage of giving a clear field for operation, and it did not seem to him that with this extract secondary hemorrhage was either more likely or less likely to occur. He had had no experience with the extract as a means of controlling hemorrhage already in progress. He had seen very intense and painful secondary rhinitis follow the use of a spray of the suprarenal extract. Like all new remedies which give great promise, it must pass through the crucible of experience before we understand its real value.

Dr. C. G. Coakley said that he had not himself found secondary hemorrhage more frequent since making use of the suprarenal extract. He had observed the irritating effect of the extract mentioned by the previous speakers, when he had made use of the boric acid solution of the extract or of the powdered extract. Thinking that this untoward result might have been due to direct infection from using an improperly sterilized solution of the extract he had made use, for some months past, of the extract dissolved in a one per cent solution of resorcin. He had now in his possession some of this resorcin solution, which had been prepared last May, and it was still free from decomposition, and was as active as ever. If the suprarenal extract could be kept in contact with the surface which was actively bleeding, it would check the hemorrhage. This he had observed in two or three instances, notably in a case in which there

had been rather free oozing after incision of the lingual tonsil, and again after excision of the faucial tonsils. In these instances the hemorrhage had been very promptly and completely controlled by letting the patient swallow some of the powdered extract. In the application of the extract to the turbinals, and other exostoses, he simply wipes the solution over the field of operation.

Dr. Quinlan spoke of recent experience with the extract in cases of hemorrhage. One of these had been an obstinate hemorrhage following an attempted suicide from swallowing acid. The man had been made to swallow about half a drachm of the extract, with the result that the hemorrhage had been promptly checked. In two other cases of hemorrhage, due to ulceration, a similar result had followed the use of this extract. Regarding the practice of packing the nasal cavities with gauze, or other material, the speaker said that he was of the opinion that these applications exert an intensely hydremic effect on the tissues, and that better results were obtained by avoiding the use of all packing. The irritation caused by such foreign bodies (as tampons) had seemed to him to more than counteract any possible good that might follow their use. Again he had not had many secondary hemorrhages after operations. He could not accept all the marvellous statements that had been made regarding this seemingly wonderful extract (supra-renal) but time and experience would thrash the grain from the straw.

Dr. T. R. Chambers said that he had abandoned all packing of the nasal cavities for the past three years, and he had not had any hemorrhages until he had begun the use of the suprarenal extract. He had observed these hemorrhages sometimes several days after operation, and while the extract might not have been responsible for this, it was certain that he had not met with such hemorrhages before beginning the use of the extract. Its chief value is as an aid in diagnosis in the posterior nares and for relieving superficial and ciliary ocular injection.

Dr. Bates said regarding the occurrence of rhinitis after suprarenal extract, that he had only used the powdered extract in the nose in one instance, and in that one it had caused infection. In one very active nasal hemorrhage, occurring in a "bleeder," he had succeeded in checking the hemorrhage promptly by syringing out the nose with suprarenal extract. It had recurred two or three times, but had been controlled in each instance by a repetition of the syringing.

Dr. McKernon said that he had seen some of these irritating effects from the use of the suprarenal extract, but none since he had made use of a solution of the extract in hot camphor water.

SAN FRANCISCO SOCIETY OF EYE, EAR, NOSE AND THROAT SURGEONS.

February Meeting.

The president, Dr. Henry L. Wagner, in the chair.

Dr. W. F. Southard presented to the society a man aged about thirty whose case illustrated the extensive ravages of syphilis of the throat and larynx. The soft palate is cicatricially adherent to the walls of the pharynx, so as that the naso-pharynx communicates with the pharynx only by a small hole close to the rear wall in the middle.

Dr. Southard also showed a young Russian with extensive ulceration of the larynx. No bacilli had been found after several examinations of the sputum.

DISCUSSION.

The president thought that the second of Dr. Southard's cases was probably one of scleroma.

Dr. W. A. Martin had now a case under his care with total occlusion of the naso-pharynx from adherent palate. The patient had been treated several years for syphilis. He had removed a large sequestrum of the hard palate. The question now is, how to free the palate and keep it free. He did not consider the laryngeal case one of scleroma, since ulceration does not occur in scleroma.

The president said that the fact that the patient is a Russian was in favor of scleroma. In Austrian clinics we see these cases, and he had seen several in which there was ulceration.

Dr. Southard stated that there is dullness of the patient's chest on examination. He would have scrapings of the ulcer examined microscopically.

Dr. Kaspar Pischl presented a specimen of carcinoma of the esophagus and larynx. The patient was an engineer, aged fifty-six, who had been treated for one year for enormous hypertrophy of the turbinated bodies and also of the pharyngeal tonsil. He complained that especially in the morning he had to gag and cough to clear his throat from mucus. The nose was nearly always closed. The enlarged tonsils and adenoids were removed, and breathing became easy. Three months ago, after a severe cold, there was so serious an attack of dyspnea that tracheotomy was performed. For nine weeks after, the laryngoscope showed only swelling of the ary-epiglottic folds. Some swollen glands were felt. The temperature was always below 99°. Later the pulse became weak and irregular and over 100°, but was made regular and slower by digitalis. The day

preceding his death the temperature was 101°, pulse poor; strong again after digitalis. At 7 a. m. on the day he died, temperature 101°, pulse 112; digitalis; injection of strychnine 1/40 gr. At 10 a. m. patient died suddenly while sitting. Death certificate: Carcinoma of esophagus and larynx. *Post-mortem:* Anterior wall of esophagus slightly ulcerated and transformed into a hard, flat plate. On left arytenoid is an ulcer about 1 mm. by 1/2 mm., apparently covered during life by the much larger swollen right arytenoid. Epiglottis folded frontally. Sides of larynx fastened to surrounding tissue by infiltration of many flat glands, which, on section, clearly show a carcinomatous infiltration, and this is confirmed microscopically. The heart was soft; some old infarcts in the periphery of the kidneys. The immediate cause of death was probably septicemia.

Dr. Wagner demonstrated a specimen of epithelioma on the right side of the larynx in which the whole right side of the larynx had been excised; also microscopic section of the same.

Dr. Charles G. Levison, by invitation, reported the operation done by him recently on a patient, presented at a previous meeting, with carcinoma of the tongue and tonsil. He spoke as follows: "Dr. Wagner has asked me to describe the operation performed upon his case of cancer of the tonsil, which he kindly referred to me. The patient, though seventy-seven years of age, was in fair physical condition. Arteries good. Examination revealed a growth of the left tonsil (which was fully described by Dr. Wagner) as well as a decided glandular infiltration at the angle of the jaw. The most distressing symptom experienced was a progressive dysphagia. After consulting with Dr. Wagner, it was decided to perform a radical operation to relieve the condition, which, as a whole, was most unfavorable. According to most writers, radical operation is considered unwarranted, even in the earliest stages of the disease, as the results are almost always bad, although Mickulicz reports the case of a woman who for two years survived the operation. Before describing the operation done by me, I will give a brief résumé of the operations advocated, of which there are three, namely: Cheever's, Czerny's and Mickulicz's. All the operators advocate a preliminary tracheotomy. Cheever makes an incision along the anterior border of the sterno-mastoid, from the level of the ear to below the level of the growth, and a second incision, at an angle to the first, is carried along the body of the inferior maxilla. In this operation little cutting is advised, the tumor being removed preferably by the galvano-cautery. Czerny cuts from the angle of the mouth outward to the border of the masseter, and beyond it to the hyoid bone, sawing through the jaw between the second and third

molar teeth, and when the jaw is drawn apart the tumor is laid bare. After the removal of the growth the jaw is reunited with silver wire. Mickulicz's operation is still more formidable. He makes an incision from the mastoid to the hyoid bone, raising the soft parts from the jaw bone, avoiding the facial nerve, then resecting the ascending ramus of the maxilla. When the bone is removed the tonsillar region (without retraction of the fragment of bone) is at once exposed. Mickulicz claims great ease in reaching the desired area, ease in removing the infiltrated lymphatics and facility in keeping the wound clean. He claims great advantage in the resection of the jaw, as the contracture which results in all operations upon the bone in this region does not occur. The bone removed is partially restored by the periosteum.

"I will now briefly describe the operation as I carried it out. A preliminary tracheotomy was first performed without difficulty, the anesthesia being subsequently conducted through the tracheotomy tube. The pharynx was then plugged with gauze, which prevented any escape of blood to the trachea. An incision was made from the mastoid to the greater horn of the hyoid. The periosteum was raised from the angle of the jaw anteriorly and posteriorly, and the jaw sawed through its angle and ascending ramus by means of the Gigli saw, removing about 1½ inch of the same (ascending ramus). The tracheotomy and jaw resection not occupying longer than five minutes, the tumor at once presented in the wound. Exploration revealed the condition of a decidedly infiltrated pharynx and tongue, the base of the latter being reached with the greatest facility. With this condition present it was decided impracticable to go any further. The wound was closed, and despite the patient's years, he reacted perfectly from this formidable operation, which, nevertheless, was comparatively bloodless, as but two hemostats were applied, one of these being to the facial. The patient progressed without difficulty for thirty-six hours with normal pulse and temperature, and then, from no apparent cause, his breathing became rapid and he died in a few hours."

DISCUSSION.

Dr. Eaton had found Dr. Levison's description of the operation of great interest, and thought it well that the laryngologist should be acquainted with the general surgeon's point of view. He had seen this patient more than six months ago, and at that time there was a growth on the left side of the tongue involving the left anterior pillar with induration. He told the man that it was cancerous, and had him examined by a well-known surgeon of this city, who concurred with his opinion, and that, the tongue being involved, the operation would be a serious matter and permitted of no delay. In spite of plain warning he temporized.

NOTE.—At the March meeting ophthalmologic papers only were presented and discussed.

ABSTRACTS AND BIBLIOGRAPHY.

Arranged and Edited by

FAYETTE C. EWING, M.D., St. Louis,

with the collaboration of the

EDITORIAL STAFF.

It is our purpose to furnish in this Department a complete and reliable review of the world's current literature of Rhinology, Laryngology and Otology.

Authors noticing an omission of their papers will confer a favor by informing the Editor.

I. NOSE.

Tuberculosis of the Upper Respiratory Tract—O. CHIARI—*Berliner Klin. Wochenchr.*, Nos. 45, 46 and 47, 1899.

This voluminous paper, which runs through three numbers of the *Berliner Klin. Wochenschr.*, is largely statistical in its nature. Among 695 cases of tuberculosis of the upper respiratory tract (nose, naso-pharynx, mouth, pharynx and larynx) there were 635 cases of laryngeal affection, or about 90 per cent. After studying the statistics of various hospitals, he reaches the conclusion that tuberculosis of the tract in question occurs in somewhat less than 30 per cent of the cases of pulmonary tuberculosis. The fact that tuberculosis of the upper air tract is so much rarer than that of the lungs has led to the view that the disease of the upper region always comes about by infection from the lungs. It is the author's endeavor to study this question in regard to each of the several regions separately.

Tuberculosis of the Naso-Pharynx.

The literature of this subject is very freely quoted, and the conclusions drawn are that infection may occur in three ways.

1. By breathing in germs through the nose.
2. By contact with sputum from the lungs.
3. By way of the blood and lymph streams.

The first two are the most frequent methods of infection. In case of primary tuberculosis of the naso-pharynx we may safely assume that the infection has occurred from the inspired air. It is easy to see how infection may occur from the lungs in secondary cases, and also that in miliary tuberculosis the method of infection may be through the blood and lymph. As therapeutic deductions we have the following:

1. Every catarrh of the naso-pharynx, especially the chronic cases, should be overcome, for their presence favors the development of the bacillus.

2. Patients with post-nasal catarrh, especially children, should not be permitted to inhabit the same rooms with tuberculous subjects.

3. The various forms of tuberculosis of the naso-pharynx should be treated as thoroughly as possible. This is particularly true of the tumor form of the disease. Inasmuch as we cannot diagnose any given case by the microscope, the extirpation of every pharyngeal tonsil is justified. We may thus occasionally remove a focus of tuberculosis.

In regard to the method of infection from the naso-pharynx, numerous authors are quoted who have seen a general infection follow an imperfect removal of a tuberculous pharyngeal tonsil. The path selected by the bacilli seems to be through the lymphatics to the glands and thence into the general system. This view seems to be generally adopted.

Tuberculosis of the Pharynx.

This disease is rare. It may occur by the inspiration of bacilli or from food. Of course infection from this region may be brought about by invasion of the neighboring structures, involvement of the lymphatic glands, etc.

Tuberculosis of the Tonsils.

This form of the disease was formerly considered very rare. Of late, however, the view is gaining ground that in very many cases of long-standing pulmonary tuberculosis, the tonsils will be found to be affected. In primary cases, the disease seems to occur in the form of isolated nodules, while the secondary form is characterized by the presence of superficial ulcers, the tissues rapidly degenerating. This condition may easily be confounded with syphilis. In primary cases the whole tonsil should be instantly removed, while if the disease is secondary, we may be guided by the symptoms (dysppagia, etc.)

. The methods of infection are five:

1. Through the blood.
2. Through the lymph.
3. From the sputum.
4. From inspired air.
5. From food.

The disease may also spread directly to the tonsils from the pharynx.

Mendelsohn, who has studied the question exhaustively, thinks that the tonsils exercise no protective function against the bacilli, but rather that on account of their irregular external surface they readily harbor all micro-organisms, and favor their entrance into the general system by reason of the frequent movements to which they are subjected.

Tuberculosis of the Nose.

This trouble is somewhat rare. It seems to occur in three forms.

1. An ozena-like inflammation where the discharge seems to be filled with bacilli.

2. Tuberculous ulcerations of the nose, usually occurring on the anterior portion of the septum.

3. Tubercular tumors of the nose.

The methods of infection seem to be through inspired air, sputum, blood and lymph and direct extension from neighboring parts. Tubercular tumors of the brain and its membranes seem to originate sometimes from the nasal affection; for Flatau has shown that the lymphatics of the nose communicate with the subarachnoid space.

Tuberculosis of the Larynx.

The author quotes Schech as saying that while by far the greater number of cases are secondary, still a small per cent is undoubtedly primary in its origin. This view is opposed by many writers, and the author himself says that while primary laryngeal tuberculosis is possible, still it is very difficult to prove its existence beyond cavil. Tuberculosis of the larynx appears in the form of thickenings, infiltrations, tumor-like structures and ulcerations.

The course is very variable; it may exist for years without much change and it may lead to wide-spread destruction of tissue in a short time.

The sources of infection seem to be inspired air, sputum from tuberculous lungs and transportation by the blood and lymph. Krieg maintains that in most cases the larynx becomes affected through the lymphatics passing to it from the lungs, and cites the numerous cases where a unilateral lung trouble is accompanied by an affection of the corresponding side of the larynx. His own statistics give a far higher per cent of cases where this condition prevails than do the statistics of Magenau. The author, however, is of the opinion that the most frequent form of infection is directly from the sputum.

Tuberculosis of the Mouth.

The forms of oral tuberculosis are lupus, tuberculous tumors, infiltrations and ulcerations, which, however, seldom occur as a primary trouble. The tongue is a favorite seat of oral tuberculosis.

Lupus of the Upper Respiratory Tract.

This trouble is quite often primary, for the nasal mucous membrane is a favorite point of attack. Primary lupus has also been seen in the pharynx, naso-pharynx and larynx, but less frequently than in the nose.

Conditions favorable to the infection of the upper air tract by tubercle bacilli.

First in importance is the so-called scrofulous habit. This is accompanied by great susceptibility of the mucous membranes, with a tendency to catarrh and its consequences, such as loss of epithelium, erosions, more marked development of the lymphatic glands, etc. These latter often show a stronger tendency to become diseased than in healthy individuals.

Therapeutic conclusions:

1. Destruction of all excreta of the tuberculous.

2. All persons, especially children of a lymphatic temperament should be protected from close contact withthe tuberculous. Tuberculous parents should not kiss their children.

3. No uncooked milk should be taken.

Therapy proper. 1. The strengthening of weakly children, because anemia favors the development of the bacillus. 2. The curing of catarrhs. 3. The radical extirpation of all isolated tubercular foci. Thus lupus, tuberculous tonsils and pharyngeal tonsils, together with isolated tuberculous thickenings of the larynx, should be removed. 4. Extirpation of those lymph glands which stand in relation to isolated tuberculous foci would be a most excellent method of protecting the person from general infection. For various reasons this can rarely be done, and of course should never be undertaken until by a tuberculin injection, the glands in question have been shown to be really tuberculous. VITTUM.

Electricity in Diseases of the Nose, Throat and Ear—W. SCHEPPEGRELL—*Journ. Am. Med. Assn.*, February 3, 1900.

The principal uses of electricity in diseases of the nose, throat and ear are: 1, For illumination; 2, for cauterization; 3, for influencing vascular changes in the nasal mucous membrane; 4, for cataphoresis in cocaine anesthesia; 5, for electrolysis in the treatment of fibroid tumors of the nose and throat; 6, for operating mechanical appliances; 7, for the diagnosis and treatment of auditory nerve lesions. Galvanism and cupric electrolysis are of great value in atrophic rhinitis. In congested conditions of the nasal mucous membrane mild galvanic application stimulates the circulation by its tonic effects on the vasomotor nerves. ANDREWS.

II. MOUTH AND NASO-PHARYNX.

Tonsillitis—G. H. THRAILKILL—*West. Med. Journ.*, February, 1900.

A summary of the present views of this disease. EATON.

A Case of Recurring Quinsy Treated by Anti-Rheumatics and Thyroid Extract—MARY E. BATES—*Woman's Med. Journ.*, January, 1900.

The patient, a boy of eighteen years, of good health, but for last two years troubled with recurring sore throat, the left tonsil suppurating and spontaneously opening regularly every month for the last half year. The tonsils were alike enlarged and of fibrous structure. Patient never had rheumatism, but was placed upon a mixture of salicylates, iron and cascara, also syr. iodide of iron. Locally tinct. iodine and a silver solution (10 grains to oz.). After six months five grain tablets of thyroid extract were given three times a day, which was continued three months, after which time the tonsils had contracted to about normal size and caused the patient no trouble. STEIN.

A Second Case of Recurring Quinsy—JULIA S. KAPP—*Woman's Med. Journ.*, January, 1900.

A woman of twenty-eight, never having had rheumatism, but suffering from frequent attacks of acute tonsillitis, with suppuration, since childhood.

Two-grain doses of thyroid extract were given, repeated every hour for five hours, in addition to $^1/_{60}$ gr. strychnine. After two hours this was again repeated—2 gr. thyroid every hour for five hours. The following day 2 gr. thyroid at regular intervals until ten grains had been taken. After which time all acute symptoms had subsided. STEIN.

The Etiology of Acute Inflammation of the Tonsil—HILBERT—*Deutsche Med. Wochenschr.*, No. 43, 1899.

At a meeting of the Society of Scientific Medicine of Königsburg, held April 24, the author read a paper on the above subject. Of the forms of tonsillitis there seem to be two great classes. In the first class the angina seems to have an independent existence, and is, therefore, an idiopathic disease. The anginas of the second class, however, either form the principal symptom of a specific infectious disease as in diphtheria, or they form the initial symptoms of such a disease as in measles, scarlet fever and the like. It is obvious that these inflammations are caused by the specific germ of the disease which they accompany. The second class, therefore, is not considered in this paper.

The first class, or idiopathic sore throats, may be separated into two subdivisions—those caused by "taking cold," and like processes, and the infectious form. Now, while it is not possible, in the present state of our knowledge, to explain just what is meant by "taking cold," still there can be no doubt that inflammations do arise from this cause.

This leaves only the infectious subdivision to be accounted for. Various authors have attributed them to the different micro-organisms that are found in the deposits on inflamed tonsils. Especially is this true of the streptococcus. Hilbert undertook a series of examinations of the oral cavities of healthy persons. He found the streptococcus so universally present that he is unwilling to concede its etiological relation to tonsillitis. He regards the presence of the streptococcus in the deposits of inflamed tonsils as merely secondary and accidental. He thinks, however, that they flourish in these deposits and may find a way through the inflamed tonsils into the circulation, and thus give rise to a general infection.

In connection with this almost universal presence of streptococci in the oral cavity, Hilbert draws attention to Flügge's assertion that in speaking, coughing and sneezing a cloud of finest watery spray is driven from the mouth. This should be borne in mind by operators as a possible source of infection in abdominal operations, etc. VITTUM.

Nasal Obstruction Due to Adenoids—ROBERT M. LAPSLEY—*Med. Herald*, February, 1900. EATON.

Chronic Recurring Membranous Pharyngitis—JOHN O. MCREYNOLDS—*Journ. Am. Med. Assn.*, December 2, 1899.

The author presents a case of a lady nineteen years of age who has fair general health, but in the throat a thick, white membrane repeatedly forms. When uninfluenced by treatment the membrane will recur two or three times a week, and each time will remain a day or two, then become completely exfoliated of its own accord, leaving the throat in an apparently healthy condition. If the membrane is forcibly removed prematurely it leaves a raw surface covered by a glairy material and readily bleeds on manipulation. This condition has continued at least fourteen months. The membrane has been repeatedly examined microscopically and the bacillus of diphtheria has never been found. Other bacteria, including streptococci and staphylococci, were found in abundance, but there was nothing to prove their causative relation.

ANDREWS.

Tuberculosis of Pharynx—CLEMENT F. THEISEN—*Journ. Am. Med. Assn.*, August 12, 1899.

From a review of the literature and from his own personal experience the author finds pharyngeal tuberculosis rare, while tuberculosis of the larynx is much more common. He finds no record of the condition in children under four years. Pharyngeal tuberculosis may be primary, but it is usually secondary to lung involvement. It may be coincident to lung involvement and indicate an acute general tuberculosis. It may also be secondary to tuberculous caries of the cervical vertibræ, or to tuberculosis of the cervical or axillary glands. The ulcers probably result from the breaking through of tubercles toward the surface of the mucous membrane. The breaking down of many small tubercles forms the large ulcers. The rapid extension of the ulceration is without doubt due to mixed infection. Fränkel has demonstrated the frequent coexistence in tubercular pharyngitis of the tubercle bacillus and the staphylococcus pyogenes aureus and the streptococcus pyogenes. A positive diagnosis of pharyngeal tuberculosis should never be made without a bacteriological examination, and without first trying potassium iodide. Theisen says it is really surprising how many ulcerative throat conditions, even with positive evidence of pulmonary tuberculosis, and which clinically present all the symptoms of tuberculosis, get well when potassium iodide is administered.

Not enough attention has been given to the fact that the tonsils are of considerable etiological importance, and perhaps often the seat of primary infection in general tuberculosis. The author reports one fatal case, and one case of tubercular pharyngeal ulcer half as large as a ten-cent piece, cured by the alternate application of lactic acid and orthoform in olive oil. ANDREWS.

A Case of Vago-Accessory Paralysis—V. ZANDER—*Archiv für Laryngol.*, Vol. ix, Heft 3, 1899.

The author reports a case of this nature and gives a very clear statement of the symptoms, which were as follows:

ON THE RIGHT SIDE:

Motor paralysis of the soft palate.
Paralysis of all the laryngeal muscles.
Paralysis of the sterno-cleido-mastoid.
Paralysis of a portion of the trapezius.
Sensory disturbances of the pharynx.
Sensory disturbances of the larynx.

ON THE LEFT SIDE:

Paralysis of part of the laryngeal muscles.
Sensory disturbances in the soft palate.
Sensory disturbances in the larynx.

In addition there were present rapid pulse, rapid breathing and gastric symptoms.

The author's conclusion is that the lesion must be situated in the central nervous system, but at just what point could only, in the present state of our knowledge, be determined by an autopsy.

VITTUM.

III. ACCESSORY SINUSES.

A New Plastic Operation after Chiselling off the Entire Front Wall of the Frontal Sinus—K. GRUNNERT—*Münchener Med. Wochenschr.*, No. 48, 1899.

After describing the disfigurement that follows Kuhnt's operation, the author describes a procedure that he adopted with good results in a case where the front wall of the sinus was entirely removed. A vertical incision 2-3 ctm. long was made at each end of the horizontal incision along the superciliary ridge. This procedure formed a rectangular flap which, after being undermined, was readily drawn down into the furrow caused by the sinus. This flap was then denuded of its epidermal layer and stitched into place. Now from each side of the original incision flaps were loosened and drawn laterally and upward into the same depression resting upon the first described flap taken from the forehead. This procedure filled up the depression entirely, and the outer flap was covered with skin and union by first intention was obtained. It was feared that some cicatricial traction might be exerted on the upper eyelid, but such was not the case.

VITTUM.

The Curability of Empyema of the Maxillary Antrum—L. GRÜNWALD—*Archiv für Laryngol.*, Band ix, Heft 3, 1899.

In this valuable paper the author gives the results and his conclusions from 106 cases. In all questions of cure the conditions to

be considered are: The length of time the disease has been in existence, the nature of the secretion, the condition of the interior of the nose and of the teeth, and, lastly, possible complications. It should be remarked at the start that those cases presenting "ozena" symptoms are not considered in this paper, for they require special consideration. Many pages are devoted to grouping and analyzing these cases in every conceivable way. His conclusions are somewhat as follows:

Inasmuch as the least formidable operation which will attain the end in view is always to be preferred, the author advises that, whenever practicable, simple puncture and washing out of the cavity should be resorted to. If this can be done by extracting a tooth, so much the better. Of the twenty-three cavities so treated, forty-three per cent were healed, three per cent almost healed and three per cent improved. Forty per cent were uncured.

In choosing cases for puncture he advises that the more recent cases are most favorable, and that those cases occurring in youthful individuals offer better chances of success than those where older persons are concerned. Further, the catarrhal cases are more amendable to treatment than the purely suppurative.

In the matter of proceeding to the so-called radical operation the author is inclined to be very conservative, for, as he says, even the radical operation does not by any means insure a cure. Those cavities having the natural opening situated very high up, give a most dismal prospect of relief when simple puncture is employed, and perhaps in this class of cases one would be warranted in resorting to the radical operation, inasmuch as this gives an exit to the pus from the lower part of the cavity. Simple clearing out of the cavity effected a cure inside of three months in those uncomplicated empyemas of not more than three years' standing, where there was no nasal complication, where the mucous membrane of the antrum had not undergone marked change and where the teeth were sound.

The catarrhal cases were equally favorable, provided that the mucous membrane had not undergone much change, and when there was no secondary disease of the nose.

Suppuration of the frontal sinus prolonged the cure of two cases which otherwise corresponded to the last mentioned. These cases were treated by freely opening the cavity from the canine fossa and covering the bone with the loose mucous membrane so that the opening could not rapidly fill up and heal.

This operation, however, offers very little hope in those cases with marked bony disease of the antral walls, or loss of a large part of the mucous membrane, or with the ostium maxillare situated high up, or where the secretion is of a bad character.

Here, too, should be reckoned those cases where symptoms of ozena are present. In these last the percentages of cures is too small and the time of after treatment too long to warrant us in recommending the operation. For all these latter classes the radical operation only may produce a cure.

In closing, he emphasizes the statement that there is a large class of catarrhs which should not be operated on. These seem to produce no secondary effects, like polypi, lasting nasal obstruction, severe laryngitis, etc., nor do they seem to give rise to marked disturbances of any kind.

These cases should be treated symptomatically, the passages kept clean, hypertrophied turbinals shrunk, polypi removed, etc., and this treatment will often be most satisfactory. VITTUM.

IV. LARYNX AND TRACHEA.

Speech and its Disorders—JOHN A. CALDWELL, JR., Cincinnati—*Cincinnati Lancet-Clinic*, October 28, 1899.

The author's study consists of a somewhat exhaustive review of the present knowledge of the physiology and disorders of speech. It is classified into three separate categories, reception, retention and emission, under which headings the phenomena of speech are first studied, and then the various aphasias are considered.

STEIN.

The Acute Inflammations of Larynx—ALFRED GOLDSCHMIDT—*Bresgen's Sammlung*, Band iii, Heft 7.

The author gives a succinct review of the various acute inflammations of the larynx, both as they occur idiopathically and when they appear as sequelæ of the infectious diseases. The pathology and etiology are touched upon and the treatment discussed to some extent. Nothing of particular interest and nothing new is developed.

VITTUM.

Membranous Obstruction of the Larynx—W. JAY BELL—*Atlanta Journ.-Record of Med.*, February, 1900.

Membranous croup is the form of laryngitis in which the streptococcus is the pathogenic factor, and diphtheria, when this is the Klebs-Löffler bacillus. Intubation is the most important procedure in these cases. In fourteen intubations in the hands of the author, there were ten recoveries. W. SCHEPPEGRELL.

Report of a Case of Laryngectomy—G. T. HANKINS—*Australas. Med. Gaz.*, January 20, 1900.

The patient's age was forty-two, and when seen complained of hoarseness and occasional loss of voice, and of feeling a lump in the throat when swallowing, but of no actual pain. The lump had broken and discharged pus on six occasions. There were enlarged glands below the angle of the jaw. No specific history. No external deformity in the neighborhood of the larynx, which is freely movable.

Laryngoscope shows a lump 1 inch by ¾ inch in left hyoid fossa, pushing the epiglottis across the middle line and hiding the left, and the greater part of the right, vocal cord. Patient was kept on full doses of iodide for three weeks, when it was decided to operate, the diagnosis being epithelioma.

Preliminary tracheotomy was done with insertion of Semon's tampon. Incision above and parallel to great cornu of hyoid bone to locate growth. Finding this below that level, a transverse subhyoid incision was made, separating the epiglottis from the tongue and hyoid bone. This was joined by a vertical one reaching to within half an inch of the tracheotomy wound. The perichondrium and soft parts were stripped from the left ala of the thyroid cartilage, the latter divided in the middle line, the arytenoids dislocated from the cricoid, and the half larynx removed with the epiglottis attached. There was no difficulty about the operation. The mucous membrane was sutured so as to shut off the pharynx as much as possible from the operation wound. A No. 16 rubber catheter was passed into the esophagus with its end coming out through the mesial incision in the neck, and the upper part of the trachea plugged with iodoform gauze. Esophagus tube removed on second day, and patient fed himself with a feeder to which the large catheter was attached. On the eleventh day the tracheotomy tube and tracheal packing were removed, and the patient found he could speak in a whisper.

Patient made complete recovery. EATON.

Laryngospasm, Eclampsia and Tetany in Children, and Their Connection with Rachitis and with One Another; Laryngospasm and Enlarged Thymus and the Lymphatic Constitution—ADOLF BAGINSKY—*International Clinics*, Vol. I, Ninth Series, April, 1899.

Laryngospasm is discussed as the main feature of a symptom complex which has long been recognized and written about under various names, the most common, besides laryngospasm or laryngismus stridulus, being spasmus glottidis, asthma rachiticum, Kopp's asthma and asthma thymicum.

The lecturer asserts that, almost without exception, laryngospasm develops in rickety children, and that the connection between rachitis and laryngospasm is not a mere coincidence, but that the former stands in a causal relation to the latter, in that it provides a groundwork upon which develops an unstable nervous equilibrium, which is upset by any slight unusual irritation, and leads to the characteristic nervous explosion, in the delicate nerves of the larynx, constituting laryngospasm.

Three cases are presented, in each of which the patient was pale and delicate-looking and showed the classical symptoms of rachitis —the square head, the wide-open fontanelles, the enlargements of the ends of the long bones, something of the "rickety rosary" in the beaded enlargements of the ribs where they join their cartilages, and, finally, the prominent abdomen.

In the severer cases of laryngospasm an attack is apt to be followed by general convulsions, which may be brief or considerably prolonged, during which there are twitchings of the fingers and clonic movements of the limbs.

Even between these movements there is persistent spasm, shown by the resistance to any attempt at flexion of the limbs. The diaphragm is involved in the clonic contractions, sometimes giving rise to a peculiar jerky respiration. The abdominal muscles are spasmodically contracted, the legs are in spasm, and all the senses and cutaneous reflexes are in abeyance. This is the ordinary picture of eclampsia or convulsions in children, and the connection between laryngospasm and eclampsia is betrayed by the gradation seen in the attacks and by the one condition following so closely upon the other.

In many of these cases there develops the set of nervous manifestations which constitutes tetany, and in nearly all cases tetanic twitchings of the muscles of the face and limbs may be induced.

From the frequent occurrence together of the three conditions named, and that, too, almost without exception, in rachitic subjects, the lecturer argues that they are closely related to each other, and that rachitis bears an etiological relation to them.

Enlargement of the thymus and the lymphatic constitution doubtless also play an etiological role in laryngospasm—the former largely by exerting pressure on the trachea and larynx, the latter through producing an organism which is poorly nourished, unresistant to toxic and bacterial action, and supplied with an ill-balanced nervous system.

As to the treatment of laryngospasm and accompanying conditions, the administration of phosphorus is strongly advocated.

Recourse must sometimes be had to the bromides or musk. Any coincident affection, liable to cause reflex nervous trouble, must, of course, receive proper attention.

When eclampsia develops, chloral hydrate is, perhaps, the most efficient remedy.

Where other remedies fail, leeches may be applied over the mastoid, and, if a fatal termination be threatened, venesection is advised. Ross.

V. EAR.

Acute Inflammation of the Middle Ear Complicating Scarlet Fever and Measles—Chas. H. May—*Archiv. Pediatrics*, July, 1899.

Unchanged but more general treatment of the ear has reduced this complication during the last ten years. About 20 per cent of all cases of scarlet fever have ear complications. They are more usual in winter. Two classes, the *catarrhal* and *purulent*, named according to the character of the discharge, though clinically it may not be possible to differentiate until after perforation. Streptococci, staphylococci and pneumococci are found in the discharge, and there is reason to

believe the character of discharge depends upon nature of infection by the micro-organisms. Streptococci, likely responsible for severe form. Probably majority of cases of otitis in measles are catarrhal form. As majority of otitic complications occur at end of first week, when fever has subsided, a sudden rise of temperature is an important diagnostic sign indicating inflammation of the ear. At an early stage there will be more or less redness of membrane, which if limited to Schrapnell's membrane indicates a severe type, and purulent. In early stage resolution may occur by pus escaping through Eustachian tube, but such an event will not take place if the accumulation is purulent. Treatment should be *preventive*, which means antiseptic washes, cleanliness, in the nasal passages; *abortive*, treatment in the early stages tending to prevent perforation; *paracentesis*, when the abortive treatment is unsuccessful. Bulging of membrane demands radical paracentesis, or even a good slit. Upon the disputed question of inflation in scarlet fever and measles the author occupies an affirmative position. "*But it must be used properly*," which means *gently*, preferably by catheter, with accompanying suction of the tube and tympanum. This is accomplished, after the catheter has been introduced and the ear inflated, by placing the finger upon the valve of the bag while in a compressed condition. The elasticity of the bag tends to cause it to assume its original shape, and as no air can enter, suction is generated. When the finger is kept on the valve constantly no progress is made since the suction causes the tube walls to collapse, but if a little air is permitted to enter by alternately releasing and applying the finger for a moment at a time the contents of tube and tympanum tend to be drawn towards the catheter. If catheter cannot be employed, suction may still be possible following inflation by Politzer's method. Mild purulent and catarrhal cases may often be aborted by this procedure. The physical signs upon inspection must determine the necessity for paracentesis. The author ends with this italicised axiom: *When in doubt incise.* F. C. E.

On the Conduct of the Mastoid Operation for the Cure of Chronic Purulent Otorrhea, with Special Reference to the Immediate Healing of the Cavity in the Bone left by the Operation by Means of Epithelial Grafts—CHARLES A. BALLANCE.

With remarks on the selection of cases for the operation by Sir William Dalby.

Paper read at the meeting of the Royal Medical and Chirurgical Society held on Tuesday, January 23, 1900.

It is pointed out:

1. That the progress in the surgical treatment of suppurations in the temporal bone during the last twenty years is due *(a)* to an increase in anatomical and pathological knowledge and *(b)* to the adoption of true surgical principles.

2. That the selection of cases for the complete mastoid operation is surrounded with difficulty, and that large experience rather than

rigid rule is the best safeguard against, on the one hand, the risk of delay, and, on the other, the performance of an unnecessary operation.

3. That the cure of chronic otorrhea cannot be effected by a simple opening into the antrum.

4. That the complete mastoid operation which involves surgical damage to the tympanic structures is inapplicable to and unjustifiable in acute cases.

It is proposed that typical intractable cases of chronic otorrhea should be treated by two operations:

1st. *The operation for the removal of the disease*, namely, the complete mastoid operation.

2d. *The operation for the healing of the wound*, namely, by the epithelial grafting of the raw bone cavity.

Lastly the operations are described and notes of twenty cases are appended.

Sir William Dalby's remarks deal chiefly with the selection of cases of long standing for the complete operation, with skin-grafting. As undoubtedly necessary are mentioned:

1. Cases in which septicemia has commenced.

2. Cases in which there is dead or carious bone in the tympanic cavity, accompanied by ominous symptoms often repeated.

3. Whenever there is evidence of mastoid disease of long or short standing.

As open to question are:

4. A certain proportion of cases where, although there is evidence of dead or diseased bone, there is no reliable history of ominous symptoms.

5. Cases of intractable otorrhea without bone disease or ominous symptoms.

Cases are also discussed in which a less complete operation (which, however, includes free posterior drainage) is necessary.

StClair Thomson.

Chronic Middle-Ear Suppuration with Thrombosis of the Lateral Sinus in which the Internal Jugular Vein was not Ligatured; Recovery—Arthur H. Cheatle—*Lancet*, January 13, 1900.

Thrombosis of the lateral sinus occurring during the course of otitis media may have either of two pathological causes. On the one hand, it may be due to the passage of micro-organisms from the middle ear through the wall of the sinus; thus a thrombus is formed, which contains the bacteria which have given rise to it; this clot readily breaks down, and therefore in these cases there is a very great probability of the occurrence of embolic pyemia. On the other hand, the blood may clot in the lateral sinus, owing merely to a "spread of the inflammation" from the surrounding structures; in this case the coagulation is probably the effect of the transudation of toxins, and the clot so formed is firm and has little or no tendency to become disintegrated. It is not possible to distinguish clinically between these two conditions until some infec-

tive manifestation occurs, such as a pyemic embolus; but a rigor is very suggestive, and is quite sufficient to justify ligature of the internal jugular vein. A case somewhat similar to the one recorded below has been published by Röpke.*

A boy, aged fourteen years, attended on June 26, 1899, complaining of pain round the left ear and of vomiting. Eighteen months previously he had had a discharge from both ears which "was stopped." On two occasions since then he had suffered from earache, but there had not been any discharge. Five days before being seen at the hospital he had pain in his head and commenced to vomit. The pain, which was at first intermittent, had become continuous. The vomiting had caused great distress, and, as no food could be retained, he had rapidly lost flesh. Two days before admission the ear had discharged, with some relief to the pain. Giddiness had been complained of for two days. A marked shivering fit occurred during the night before the visit to the hospital. The boy looked wasted and anxious, and was extremely restless. He was sensible and answered questions readily. On walking he had a tendency to walk towards the right. The temperature was 100.2°F., and the pulse 104. An offensive brown discharge came from both ears, a perforation being present in Shrapnell's membrane on each side. Marked tenderness on pressure was present behind the mastoid process and below the ear, where glandular enlargement could be felt. The heart and lungs were normal. Papillitis was present in both discs equally.

The antrum was found to be full of granulations and cholesteatomata. On laying the antrum into the middle ear the malleus and incus were found, both carious. The attic and middle ear were then thoroughly cleared. On examining the walls of the antrum, a discolored and softened patch of bone was found in the posterior, leading directly to the lateral sinus. The sinus having been exposed for over an inch of its length, it could be seen that it was occupied by a firm clot, which was dark in color except at the point of infection, where it was slightly yellow and evidently breaking down. As giddiness had been a marked symptom, the cerebellum both in front of and behind the sinus was thoroughly explored, but with no result. The dura mater, which had been incised, having been stitched up with catgut, the sinus was laid open for the whole of its exposed length and the clot was turned out. As the clot for some distance above and below the point of infection was dark-colored and firm, it was decided not to tie the internal jugular vein, but to clear the thrombus out as far as possible from the wound. For this purpose a sharp spoon was first carefully passed downwards, no bleeding occurring. A gauze plug having been prepared, the spoon was passed backwards towards the torcular; after some clot had been gently removed, a free gush of blood took place, shooting out a healthy-looking mass of clot fully one and one-half inches in length. The bleeding was

* *Archives of Otology*, Vol. xxv, No. 4.

easily controlled by the plug. The whole wound was then packed with iodoformed cyanide gauze. The operation occupied one and a quarter hours. An hour after the operation a rigor occurred, the temperature reaching 102.4°. From that time the progress was steady and uneventful, but slow.

That ligation of the internal jugular vein is not always necessary in thrombosis of the lateral sinus is well recognized, but no guiding rule has been laid down. Young* has described a case in which recovery took place without ligature of the vein, and no doubt many surgeons have had the same experience. Bronner has related a case in which the clot as seen through the wall of the sinus looked healthy throughout, and it was therefore left unopened, with a happy result. It seems that if healthy-looking clot can be seen well below the breaking-down area ligation of the vein is not necessary; but in order that such a condition may be found it must be well recognized that *one* rigor demands instant operation. A rigor does not necessarily mean that there is septic thrombosis of the sinus, for in a case under the care of Dr. Urban Pritchard in King's College Hospital a severe rigor occurred as a result of an acute empyema of the antrum, and no further bad symptom followed after removal of the outer wall and evacuation of the pus. But it cannot be too strongly insisted upon that there should be no waiting after a rigor has occurred during the coming of an acute or chronic middle-ear suppuration; the antrum should at once be opened and the sinus examined. An interesting point about the case related is that, although the boy was perfectly well, the optic neuritis was present at least three months after the operation. The giddiness which was such a marked symptom was due, in all probability, to disturbance of the intracranial circulation owing to the occlusion of the sinus. StClair Thomson.

VI. DIPHTHERIA, THYROID GLAND, ESOPHAGUS, ETC.

Two Cases of Tumors of the Esophagus Removed by Sub-Hyoid Pharyngotomy—W. Permewan—*Liverpool Medico-Chirurgical Journal*, No. 37, 1899.

The operation in each case was performed in the usual manner, after preliminary tracheotomy, except that the epiglottis was deliberately cut off from the thyroid so that its attachments to the tongue were not severed. In the first case, a fibro-myxoma was easily removed, the epiglottis stitched to the thyroid and the wound closed completely. Everything went well for seven days and then the tracheotomy tube was removed. The following day the wound began to break down and gaped widely in a day or two. Meanwhile the patient developed septic bronchitis and died on the tenth day.

* *Glasgow Medical Journal*, October, 1899.

In his second case, a growth similar in appearance and position to his first, but on section proving to be a carcinoma, was removed, though with greater difficulty and less completely. But then, instead of stitching up the wound, the author plugged it with gauze and left it absolutely open. The patient recovered from the operation without a rise of temperature and the wound was almost closed at the time of reporting.

The author considers that the difference between the failure and success of these two operations (as far as the immediate success of operation is concerned) entirely depended on the after-treatment, and concludes that in this, the example of Butlin, in thyrotomy, should be followed, and the wound left open, no attempt at primary union being made. P. WATSON WILLIAMS.

Extensive Mediastinal Emphysema in a Fatal Case of Laryngeal Diphtheria; with Remarks on the Early and Late Variety of Emphysema Observed in the Case after Tracheotomy—W. EWART AND H. B. RODERICK—*Lancet*, December 30, 1899.

The following case is a striking illustration of a complication to which diphtheria of the larynx and trachea is liable in spite of tracheotomy and of antitoxin, and the fatality of which is probably attributable to the cardiac and pulmonary embarrassment set up by the increasing distention of the areolar tissue of the anterior and posterior mediastina and of the root of the lungs.

The patient was a child, aged five, who was admitted for threatening suffocation, and tracheotomy had to be performed within twelve hours. Four thousand units of antitoxin were injected immediately after the operation. Next day emphysema began to develop; this increased; membrane was coughed up, and the patient died within three days. There is no mention of the diphtheria bacillus being found.

Necropsy.—The post-mortem appearances twenty-four hours after death were as follows: There was great subcutaneous emphysema of the neck, face and eyelids, the aspect being very similar to that met with in acute renal dropsy. Neither fluid nor adhesions were found in the pleural cavities. The lungs showed localized patches of collapse. There was great emphysematous swelling of the loose tissue in the anterior and posterior mediastina and about the roots of both lungs. This extended up around the trachea, but owing to the density of the tissues was not so considerable. The trachea showed a tracheotomy wound with sloughy edges and pus in the tube. The true and false vocal cords and the under surface of the epiglottis were abraded, and small shreds of a membrane-like substance were recognizable about the epiglottis. The tonsils were practically normal, and the soft palate was merely edematous.

Remarks.—We are reminded by this case that after the relief of a membranous obstruction of the larynx by tracheotomy a membranous trachitis may still remain, and may be latent for a while, and that it is important to frame our treatment from the first in all cases with a view to this possible contingency. The existence of

a false membrane lining the trachea and bronchi was not suspected until its detachment led to a suffocative attack; and after the operation the air entry was so good that the precaution of introducing creasoted oil into the trachea immediately after the tracheotomy and every two hours subsequently was not adopted until it was too late for it to be of any service. The case also affords an instructive demonstration of the mode of production of the two varieties of subcutaneous and mediastinal emphysema. That which was immediately induced by the tracheotomy is well known to be a frequent complication of that operation. The other form of emphysema, which is less common after tracheotomy,* is more likely to occur at a later stage, when the distension of some of the pulmonary alveoli under stress of bronchiolar obstruction has gradually reached bursting-point. More distinctive than this relative lateness, which is not an invariable feature, are the suddenness and the rapidity of the development of the swelling after expiratory strain—in this case that of violent and prolonged coughing—which contrasts with the more gradual air-infiltration of the inspiratory form of emphysema.

In the absence of any known means of relieving its results or of checking its progress, a recognition of this serious complication of diphtheria is a guide to prognosis rather than to treatment. The leak of air in this form of emphysema is beyond the reach of any local measures. An obvious indication would be to allay the tendency to cough, but in carrying this out too completely we might deprive the patients of the only means of clearing the tubes of their obstruction by diphtheritic products.

The continuous inhalation of oxygen through the tracheotomy tube, inasmuch as it favors a diminution of the respiratory efforts and a relative apnea, would seem to be the most appropriate form of respiratory treatment. StClair Thomson.

Foreign Bodies in the Air Passages—C. A. Meisenheimer—*Carolina Med. Journ.*, February, 1900.

No time should be wasted with emetics, sternutatories, inversion of the body and such like means, but an operation should be undertaken at once to relieve the patient of the danger of suffocation.

In the first three cases the foreign bodies—pin, broken end of parasol and melon seed respectively—tracheotomies were done, resulting at once, or subsequently by coughing, in the elimination of the foreign body.

The fourth was a grain of corn in the trachea, which was coughed up on the third day. The fifth, a thimble, was removed by a tracheotomy. The sixth was a glass bead, which was located in the trachea by the X-rays, was removed by tracheotomy.

W. Scheppegrell.

* Dr. J. K. Fowler ("The Diseases of the Lungs," by Fowler and Godlee, 1898, pp. 181, 182) gives several cases which may include, besides a case in which tracheotomy had not been performed, instances of this non-traumatic variety.

Report of a Case of Pseudo-Diphtheria—FRANK L. STILLMAN *Columbus Medical Journal*, December, 1899.

The patient was a man of twenty-two years subject to recurring tonsillitis. Had a slight rise of temperature. Follicles in both tonsils enlarged and containing white, ill-smelling debris. A pseudo-membrane covered both tonsils, also the gum and cheek about the left lower wisdom tooth. The membrane was removed with some difficulty and left a bleeding surface. Microscopical examination showed no Klebs-Löffler bacillus. Cultures from the left side showed streptococcus exclusively, while the right side showed staphylococcus. Urine examination was negative. Duration of illness three weeks. STEIN.

A Few Notes on Ear, Nose and Throat Work as Taught in Berlin and Vienna—JULIUS E. KLOTZ—*The Canadian Practitioner and Review*, December, 1899.

After giving details of the operative work done on the cadaver in that city where "any number of temporal bones are at one's disposal," the author says:

"Of the most recent drugs employed here at present—meta-cresol-anitol and phenolo-rabium-sulpho-vicinicum may be mentioned in connection with the treatment of ozena.

"Tri-chlor-acetic acid is used for the reduction of nasal hypertrophies. For removing adenoids, Kirstein's ringmasser is considered the most suitable. Iodoglycerine is almost universally employed in the treatment of atrophic rhinitis, largyngitis and phargnigitis sicca."

GIBB WISHART.

Early Intubation in Laryngeal Diphtheria—WILLIAM E. TOWER—*The Cleveland Med. Gazette*, January, 1900.

After an experience of eighteen months the author urges the importance of early intubation in laryngeal diphtheria. Many of the deaths from diphtheria result from laryngeal obstruction when intubation is not practiced, or from broncho-pneumonia following late intubation. The advantages of early intubation are the greater strength and resistance of the patient, the shorter period necessary to wear the tube, the time usually not exceeding twenty-four to thirty-six hours, and the lessened danger of introducing septic material into the trachea with the nourishment because of the short time the tube is in the throat. Antitoxine should be given at the inception of the disease and intubation done at the first symptoms of prolonged inspiration, slight stridor, supraclavicular retraction, or marked restlessness. Nourishment should be administered per rectum. DETWILER.

VII. NEW INSTRUMENTS AND THERAPY.

Strictures of the Esophagus with a Device for Their Dilatation, Illustrated—TUCKERMAN—*The Cleveland Med. Gazette*, January, 1900.

The author accomplished the dilatation of a stricture of the esophagus, located seven inches down and in three bands, by means of the Wales bougies slipped over an ordinary whale-bone esophageal bougie to serve as a guide. The treatments were given at intervals of about a week, and resulted in dilating the stricture from the size of a bougie measuring No. 27 French to one measuring No. 45 French. DETWILER.

Quick Method to Cure a Cold in the Head—A. S. BARNES, JR.—*Interstate Med. Journ.*, October, 1899.

The method consists in a hot bath and warm bed; $^1/_8$ of a grain pilocarpine muriat is then administered and after three-quarters of an hour of sweating $^1/_{100}$ grain of atropine is taken. This is followed by a prescription containing phenacetine, salol and caffein citrate at intervals of two hours. F. C. EWING.

Aqueous Suprarenal Extract—JOSEPH MULLEN—*Journ. Am. Med. Assn.*, May 20, 1899.

When applied locally to any mucous surface aqueous suprarenal extract produces a more or less profound ischemia, depending on the strength of the solution and the manner and time of its application. The local use of the extract should always be preceded by the application of a five per cent solution of cocaine. The therapeutic principle on which the physiological action of the extract depends is its contractile power on the small arterioles and the basement membrane, thereby retaining in the tissues the cocaine, increasing the ischemia, and when the tissues are incised preventing the hemorrhage which would wash away the cocaine and terminate its anesthetic effects. After the use of the extract the post-operative swelling is much less, and the danger of secondary hemorrhage is greatly reduced.

To make a permanent solution the author dissolves the dry extract in a one minim to the dram solution of carbolic acid in distilled water. Vansant recommends five grains of the extract, eleven grains of boric acid and half an ounce each of camphor water and distilled water. ANDREWS.

BOOK REVIEWS.

The Year Book of the Nose, Throat and Ear: The Nose and Throat by G. P. Head, M.D., Prof. of Laryngology and Rhinology in the Chicago Post-Graduate Medical School; the Ear by Albert H. Andrews, M.D., Prof. of Otology in the Chicago Post-Graduate Medical School, oculist and aurist to the German-American Hospital, etc. 8vo., cloth. Pp. 274. Price, $1.50 net. Chicago: Chicago Medical Book Company. 1900.

The editors of this book have rendered a service which merits an appreciative reception. The work represents the condensed cullings from the mass of literature on the nose, throat and ear for the year 1899. Without reading the 170 journals referred to here, one obtains the pith of their contents in this specialty, and saves not only a vast amount of time, but the cost of the journals besides. The chief fault with this work is its price—which is too low—less than the cost of one of the good journals quoted.

Not only do the compilers give useful abstracts of the various articles, they have also added briefly the results of their own observations, and they are clinicians who are conversant with the requirements of busy physicians. The general conclusions arrived at by essayists and disputants in the society discussions are summed up in concise language. Excellent discernment and discriminating judgment are shown in apportioning space and matter to the various subjects.

Of the 256 pages of text, 143 pages are devoted to the nose and throat, and 113 to the ear. A striking feature in both departments is the large number of new names that are coming to the front in these specialties.

We suggest that it would be more interesting and satisfactory to the readers, and more generous to the writers quoted, if their full names or initials were given whenever it is possible, especially when they are not widely known. However, it should not be forgotten that many journals do not extend this courtesy in their abstracts, and so the abstractors of these journals are placed at a disadvantage. This is very embarrassing when correspondence with the writers is desired. It is surprising that any journal will quote an author whose name is not considered worth mentioning in full. The publishers have acquitted themselves handsomely, and the volume is invaluable as a bird's-eye view of the year's literature on the nose, throat and ear.

S. S. Bishop.